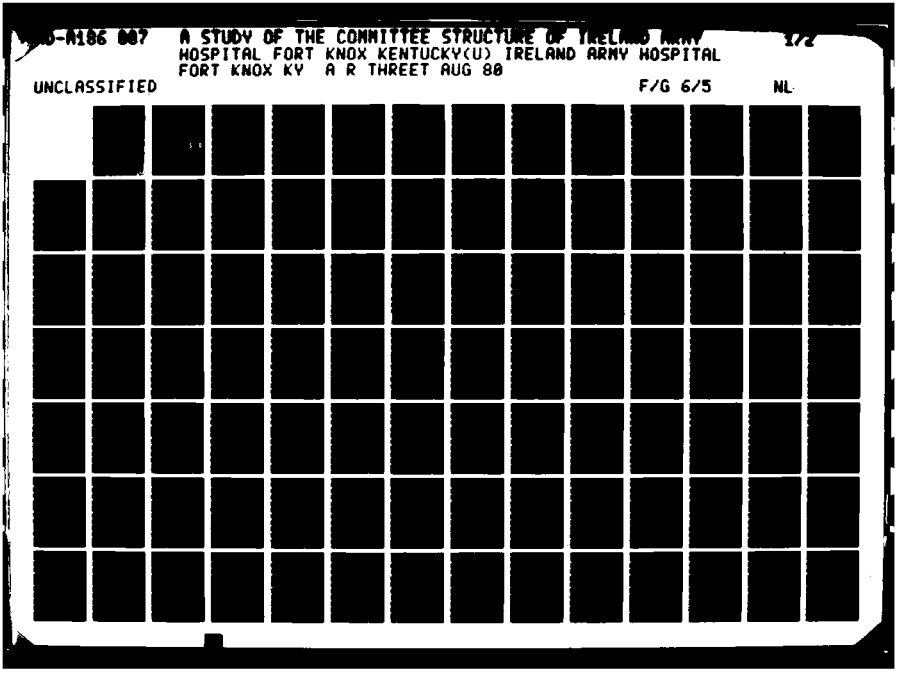
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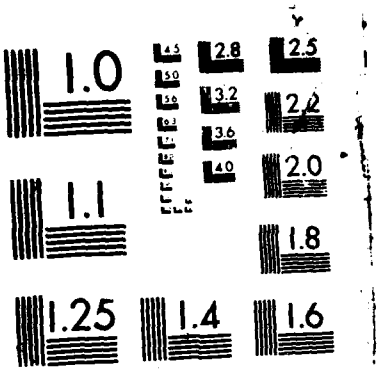

A STUDY OF THE COMMITTEE STRUCTURE OF IRELAND ARMY HOSPITAL, FORT KNOX, KENTUCKY

A Problem Solving Project

Submitted to the Faculty of

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In Partial Fulfillment of the

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By

Captain Allan R. Threet, MSC

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I. INTRODUCTION

Development of the Problem

Conditions which Prompted the Study

Increased cost and decreased productivity

There is an increasing awareness within the health care industry of the importance of health care provider productivity. Under the scrutiny of the Federal Government, it has been determined that health care institutions' costs have been rising without a corresponding rise in their productivity. This can, of course, be attributed to numerous variables such as medical technology, health care provider specialization, regulatory requirements by federal, state and local agencies, as well as inflation.[1]

AMEDD health care provider resources

Since the draft was discontinued in 1973 the difficulties with physician recruitment and retention have plagued the Army Medical Department (AMEDD). Individual medical treatment facilities (MTF) throughout the AMEDD have been forced to significantly curtail their services. These curtailments have impacted upon all beneficiaries when some specialties have been lost. For the most part, however, the loss of physicians has impacted upon specific categories of beneficiaries, primarily retirees and their dependents and even dependents of active duty members. These cutbacks have

resulted in significant public relations problems not only for individual MTF's, but for the AMEDD and the Army as a whole.[2]

Meanwhile, MTF's generally are attempting to deliver quality health care to a maximum of beneficiaries despite the physician shortages. These provider shortages and services curtailments are beginning to compound the MTF's and the AMEDD's problem in a different vein: budgetary cut-backs. Fewer health care providers treating fewer patients results in lower workload. Lower workload results in manpower recognition for fewer personnel requirements and authorizations which may potentially prompt budget cuts.

The AMEDD has attempted to counter the physician shortage by various means. Some have been progressive and far-reaching while others have been reactive and myopic. The physician assistant program is a prime example of an endeavor to relieve physicians of the practice of routine medicine in favor of more acute medicine. This health care provider-extender motif has been expanded with AMOSists, nurse practitioners and nurse clinicians. Some administrative techniques designed to conserve physician time have been the Central Appointment System from Health Services Command Ambulatory Patient Care (APC) Model #1, 1974,[3] and the Clinical Support Division (CSD), APC Model #18, 1 October 1977.[4] Both of these models have attempted and are attempting modifications of health care delivery organization and procedures in order that the physician's involvement in non-productive or non-workload

producing activities are meant to be minimized.[5]

The nature of hospital organization

It is well accepted that hospitals are unique organizations which defy the traditional molds of the business world. Instead of the mass production of like units, hospitals provide care and treatment to individual patients. Rather than low-skilled assembly-line personnel with individually assigned component tasks, hospitals deliver care and treatment to patients by the hands of highly-trained professionals, often with over-lapping and interdependent responsibilities.[6] Further, hospitals are extremely complex, matrix organizations. Matrix organizations are those in which departmentalized heirarchial coordination across departments must operate simultaneously in order to insure the accomplishment of the organizaton's mission.[7] The mechanism most utilized in hospitals to provide the lateral coordination, and thus decision-making at the lowest heirarchial level, is the committee.[8] There is perhaps no other organizational entity which is more dependent upon the functioning of committees than the hospital.

The new JCAH quality assurance standard

In January 1980 the Joint Commission on Accreditation of Hospitals (JCAH) issued the new standard for hospitals which addresses the need for a comprehensive, integrated quality assurance program. This new standard became the "focal point" of the Accreditation Manual for Hospitals (AMH) and will be a matter of concentration for JCAH Field Represen-

tatives as they conduct on-site JCAH accreditation surveys.[9] In fact, the new standard concludes with the following statement: "The effectiveness of a hospital's quality assurance program shall be emphasized in determining a hospital's accreditation status."[10] Only one other standard in the JCAH AMH spells-out so clearly the outcome for non-compliance or non-conformance with a JCAH standard.

The situation at Ireland Army Hospital

Ireland Army Hospital at Fort Knox, KY is confronted with tandem challenges of cost containment ~~with~~ and decreased productivity, and the prospects of a continued physician shortage in the face of an increasing workload. IAH's matrix organizational structure has, with the new JCAH standard in quality assurance, placed even more emphasis on the need for an effective and efficient committee structure.

It is the premise of this study that analysis and redesign of the Ireland Army Hospital committee structure and associated procedures have the potential to significantly conserve the productive time not only of physicians, but health care extenders and hospital administrators as well. Each year countless hours are expended by key members of the hospital's clinical and administrative staff in committee meetings. For the most part this time is considered both officially and unofficially to be non-productive time. This is not to say that the decisions reached or the actions taken by committees are not constructive. However, this is to say that many times committees are less than optimally

organized and administered. In addition, committees have been established and structured more often than not in response to an Army regulation or a standard of JCAH rather than in response to a demonstrated, systematic program within the hospital.

There is a need within Ireland Army Hospital, and possibly other AMEDD MTF's as well, for a comprehensive analysis of the existing committee structure and a redesign of the structure in an overall systems context. The redesign should be accomplished in such a manner as to maximize the staff's productive time, accomplish the intended purposes of the committees in a comprehensive, integrated manner and meet AMEDD requirements and JCAH standards.

Statement of the Problem

The problem is to determine the optimum feasible committee structure for Ireland Army Hospital which will maximize the staff's productive time in a comprehensive, integrated manner while satisfying AMEDD requirements and JCAH standards.

Study Objectives and Criteria

Objectives

This paper will analyze Ireland Army Hospital's existing committee structure in light of the following three objectives: to maximize the hospital staff's productive time; to maximize the hospital's committee coordination and integrative efforts; and, to insure that AMEDD requirements and JCAH standards

are satisfied.

Criteria

Criteria for evaluating the effectiveness and efficiency of the existing and redesigned hospital committee structures must take into consideration the three objectives. The first criterion is that time spent in committee meetings must be minimized. A second yardstick is that the missions of Ireland Army Hospital committees must become integrated in such a manner that committee-related information is shared and utilized by each interrelated committee. The final criterion will be the satisfactory achievement of AMEDD requirements and JCAH standards as relates to the accomplishment of administrative and clinical activities within Ireland Army Hospital.

Study Limitations and Assumptions

Limitations

For the purpose of this study the analyst must establish several limitations to the study. Failure to establish such limitations would detract from the initial concept as well as the quality of the ultimate study, conclusion and recommendations.

The study will limit itself to committees which primarily are conducted by, within, or for Ireland Army Hospital. Functions aimed at the Fort Knox Medical Department Activity (MEDDAC) as a whole or MEDDAC-community functions, such as the Health Consumer Committee, will not be addressed.

Committee functions normally discharged solely within a hospital department or division, such as the Department of Nursing's audit committee, will not be considered. The study will distinguish staff meetings and conferences from committee meetings and hence will not address the Commander's Combined Staff Conference, the Executive Officer's Administrative Staff meeting and the Chief of Professional Services' Chiefs' Meeting. Orientations, briefings, professional staff conferences and the like will also be excluded from the study. While these and the departmental/division committee meetings may benefit from managerial recommendations, they will not be specifically addressed within this study on the hospital's committee structure.

Assumptions

For the purpose of the study two assumptions will be made. It will be assumed that the mission of Ireland Army Hospital will not be significantly altered by a phase-down or a build-up of workload, personnel or budget. A significant reduction or increase of the hospital's mission and resources would have impact on the appropriateness of committee structure, membership and function. It will further be assumed that the requirements of the AMEDD and the standards of JCAH will not be significantly revised as concerns functions which are to be accomplished by hospital committees.

Review of the Literature

The literature utilized in the development of this study can easily be divided into two categories: that which

addresses general committee management and that which addresses the various aspects of a hospital's quality assurance program (QAP). The following review of the literature will be so divided.

Committee Management

While much of the work of the business world and local, state and federal government is accomplished through committees, it is ironic that committees should be so maligned. There are innumerable humorous stories which describe the disadvantages of this form of managerial decision-making. Yet, "...the underlying philosophy of all committee work is that problems are solved more satisfactorily and certain tasks are done more effectively by pooling the abilities, resources, interests, and experiences..."[11] of a group of individuals.

Definition of terms

The literature describes numerous types of committees often with nebulous and contradictory results. However, Appendix A represents a glossary of terms for the various committee types. The term "committee" is distinguished from the term "meeting." In accordance with the previously established limitations of this study the term "committee" as defined in the glossary will be utilized throughout the paper.

Advantages

Outlined within the literature are several advantages of management by committee. Experts describe the synergistic

effect whereby the deliberations and decisions made by a group of individuals have significant merit over those made by individuals.[12,13,14] Other authors cite the benefits of enhanced communications and integration as a result of staff member's common experience of serving on committees.[15,16] Secondary benefits of improved understanding of or an increased commitment to the mission or organizaion are also recognized as a result of such joint service.[17] Another significant benefit which authors espouse is the educational and training exposure which service on committees provides to junior executives toward their personal development and career progression.[18,19]

Disadvantages

The literature provides equal time and space for the detrimental facets of management by committee. Probably the most frequently cited disadvantage is the expensive nature of such a managerial mechanism.[20,21,22] One source estimates the personnel costs of one year's worth of business meetings in the United States to be $2.5 billion.[23] Another detracting feature of committee work is the general lack of responsiveness which is associated with the very nature of committees.[24,25,26] Probably one of the most exasperating features of committee management is the tendency to diffuse responsibility for decision-making and problem-solving, while simultaneously failing to assign the authority to enforce its recommendations.[27,28,29] The lack of accountability for a group decision coupled with the absence of power and authority is

a challenge to the successful operation of a committee. Another challenge is the antithesis of the synergistic notion, which causes compromise decisions [30,31] to fall victim to the "tyranny of the minority" [32] within the committee.

Keys to successful committee management

Key elements which contribute to efficient, effective committee management are identified within the literature. Each of these factors will be described in descending order of their frequency of appearance in the literature and the degree of emphasis by the experts.

The chairperson

Repeatedly throughout the literature is emphasized the absolute essential requisite for an effective committee chairperson. One source equates the committee's effectiveness to that of the chairperson.[33] Another source claims that the chairperson "...can make a 35 percent difference in the soundness of a group's work."[34] The personal characteristics of the ideal chairperson found in the literature depict a strong, charismatic leader who is able to generate the committee members' interest and to objectively guide the decision-making process with a style which is simultaneously autocratic and permissive.[35,36] The chairperson must be tireless in the coordination of and the preparation for the committee's business and must be a master at the quiet, covert manipulation of the committee members toward the successful accomplishment of the committee's business.[37] One author suggests an interesting concept as regards the

position of the chairperson in that each committee should appoint within itself an alternate or deputy chairperson.[38] Perhaps the most innovative feature of this suggestion is that a chairperson need not serve by virtue of his or her position within the organization. Additionally avoided is the loss of committee cohesiveness and direction as it attempts to orient the chairperson's replacement who is not already a member of the committee.

Clarity of the committee's mission

The literature's second most frequently stressed determinant of a committee's success is the need for a definition of the parameters, functions and the authority of the committee.[39,40] It is essential that the mission of each committee be specified as to the duration of its existence, the frequency of its convening, the nature and means of receiving its input information, of coordinating its deliberations and decisions, and of reporting its end-product. Included within the committee's job description so to speak should be an account of its relationships between other committees.[41] Further, the importance was mentioned of the functional organization of committee's as they interrelate providing input and feedback to one another.[42,43,44] One article in the literature described a procedure undertaken in a private, profit multi-institution health care firm whereby committee handbooks were developed which not only defined each committee's mission and its interrelationships with other committees but also described the roles and

responsibilities of the committees' chairperson and the individual committees' members.[45]

Committee size

Almost every source addresses the issue of the optimal size of a committee. Generally speaking, committees with four to seven members are preferred with five members considered the ideal.[46,47] While committees with up to ten members are considered acceptable, those with twelve members or more are, according to the literature, given less of a chance for success.[48] One source simply states that committee size is a variable factor dependent upon the committee's function.[49] Another expert emphasized the necessity for an odd number of committee members in order to allow for a "tie-breaking" vote.[50]

Committee membership selection

The literature mentions the necessity for careful selection of members.[51,52,53,54,55] Several prerequisites for committee members are listed by one source: They should be interested and knowledgeable in the subject at hand, possessing the authority to participate in the deliberations and the ability to perform in a group.[56] Further, that same author specifies that committee members would ideally be from the same heirarchial level within the organization and would have previously established a personal, social acquaintance with the other members.[57] Another expert emphasized the need for committee members to establish positive social relationships in a friendly atmosphere prior to the committee's

attainment of peak efficiency and effectiveness.[58] The literature defines members' roles to include punctual attendance, informed preparation, and assistance in keeping discussions on the subject.[59] Periodic rotation of committee members on a staggered basis is also mentioned as a method of enhancing committee effectiveness.[60]

Committee preparation

Steps to be taken in the effective preparation for a committee meeting are also described in the literature. Responsibility for these preparatory procedures are shared by the chairperson and the recorder. The deputy or alternate chairperson could also participate. In advance of the committee meeting the recorder should forward to each member a notice of the next meeting date, time and location.[61,62,63] If at all possible a copy of the agenda or a description of the business to be discussed should be included, enabling the committee members to become prepared for the meeting.[64] Two authors state that the agenda is the one piece of paper which will determine the success of the committee meeting.[65,66] It is further recommended that an agenda be drawn up several days in advance of the scheduled meeting for individual review by the recorder and chairperson to be followed by a joint review at least one day prior to the meeting. Joint review would be for the purpose of discussing and planning the manner in which each agenda item will be handled.[67] The agenda should be brief, but not so much so as to require lengthy explanation.[68]

Committee administration

Several factors which enhance a committee's effectiveness are cited in the literature. These include a maximization of continuity in the conduct of committee's business. Examples include regularly scheduled meeting days, times of day, and meeting location.[69] The meeting site should be spacious and comfortable, but not too comfortable as to encourage long meetings. In fact, one source described chairpersons who held stand-up meetings, turned-off air-conditioners and even convened on weekends solely to discourage prolonged meetings.[70] Meetings should begin at the appointed time. Failure to do so punishes the punctual and rewards the tardy. If this situation is not eventually corrected, the punctual will become the tardy.[71] Committee meetings should be kept on track under the leadership of the chairperson and with the assistance of the members.[72,73] The committee should establish a time limit and earnestly attempt to stay within that time frame.[74] Approximately one and one-half hours has been determined to be the maximum time limit within which a committee will productively conduct its business.[75,76] The chairperson must minimize interruptions such as telephone calls, radio pagers, et cetera in order to lead the committee toward the completion of its task within the specified time limit.[77] Committee minutes should represent an accurate summation of the meeting's discussion with a specific restatement of the what, who, how, and when of the agenda issues.[78] The minutes should be finalized and distri-

buted as soon as possible both in order to serve as a reminder to individuals with action responsibilities and to insure the accuracy of the minutes themselves.[79]

The Hospital Quality Assurance Program

Quality assurance defined

Quality Assurance (QA) is difficult to define. While the literature does not arrive at an all conclusive definition, experts have made attempts. The term quality may be defined from the perspectives of the health care provider as well as the patient. Quality assurance may indicate an emphasis on the patient's satisfaction with the health care delivery encounter or it may indicate the provider's efforts to return a patient to a prior physical or mental state following the encounter. To some experts quality care implies prolonging life, relieving distress, restoring function and preventing disability.[80]

Quality Assurance Programs described

On the basis of the myriad of QA definitions, the literature addresses the nature of hospitals' QAP's. Essentially, every activity or function which affects patient care, whether it be conducted through a heirarchial, departmental entity or a multidisciplinary, lateral entity, such as a committee, is potentially an element of a hospital's Quality Assurance Program (QAP). The literature most frequently addresses such functions as credentialing, patient care evaluation, medical record reviews or audits, blood and tissue reviews, antibiotic and drug utilization reviews,

general utilization review, and infection control.[81,82] Other writers commend the patient safety committee function and the risk management program as essential elements of a hospital's QAP.[83,84,85] One author states that "...quality assurance requires an organized program encompassing the activities of all hospital and staff committees that bear on quality."[86]

The new JCAH QA standard

The majority of the current literature regarding QA and QAP's is concentrating on the necessity for comprehensive and integrated QAP's.[87,88,89,90,91] This is largely as a result of JCAH's 1980 standard which specifically addresses QA. The new QA standard, which is effective for accreditation purposes on 1 January 1981, has five key elements. Element one requires a comprehensive QAP which is all inclusive and which integrates every facet of a hospital's efforts. The next, requirement is for a written QA plan which depicts the scope and integration mechanisms within the QAP. It is recommended that the QA plan include an organizational chart which represents the various QA committees' relationships.[92] A third element of the new QA standard is the annual reassessment of the QA plan and QAP. Element four necessitates a problem-focused approach to the review and evaluation of patient care and clincal performance. This problem-focused approach to QA encourages problem identification, priority setting, and problem assessment, resolution and follow-up. The last element requires a demonstration of the

improvement in both patient care and clinical performance.[93,94,95]

The experts have, for the most part, welcomed the new standard. They emphasize the standard's increased flexibility for optional methods of patient care evaluation and sources of data, for recognition of all QA activities some of which were previously disallowed and for the freedom from numerical requirements and arbitrarily imposed means of QAP administration and coordination.[96,97,98] Two common objections to the new standard are the increased potential for the hospital's liability and the expansion of the administrative paperwork which is the natural result of the comprehensive integration of QA efforts.[99]

Systems application to QAP's

The complexity of the organization and operation of such a comprehensive QAP has caused several authors to explore the possible application of general systems theory. One author uses a systems approach to an effective risk management program in the hospital's QAP.[100] Another author plugs risk management, medical audit and physician continuing medical education (CME) into a comprehensive QAP.[101] The patient safety committee becomes an element within the hospital QAP in another article which was subsequently field-tested in five community hospitals.[102] Yet another systems application to QAP's is the so-called "bicycle" model of CME by audit establishing a "loop" whereby medical audit identifies CME which are then evaluated through re-audit.[103] One analyst's concept of a comprehensive QAP which emphasizes departmental medical audit and CME in a

systems model is depicted at Figure 1.[104]

Perhaps one of the best systems application to QAP which has been implemented is described by Dietz and Phillips. The authors report that the administration and medical staff of a sixty-bed, acute care facility worked together in the streamlining of its eleven committees, all of which reported directly to the Executive Committee. Their goals were to increase communication among the committees and to simultaneously improve the committees' effectiveness. The reorganization centralized the eleven medical staff committee functions under three newly established committees, which assumed responsibility for the coordination of the functions previously performed by the eleven committees. Each of the three committees reports to and each of the three chairpersons are members of the Executive Committee. One interesting feature of the reorganization was the designation of an administrator to act as a liaison for each of the three major committees. The liaison's responsibilities include assisting the chairperson in preparation for and administration of each monthly committee meeting, monitoring the results of the committee's actions to insure timely follow-up, and assisting committee members with their responsibilities in relation to ad hoc or sub-committee functions. Satisfaction with the reorganization was summarized as follows:

> "Perhaps of greatest importance to physicians is that the amount of physician time spent in committee work has been reduced from 700 to approximately 300 hours per year. Physician time saved over a year is not only cost effective, but appreciated by the busy practitioners as well."[105]

SYSTEMS MODEL OF A COMPREHENSIVE, INTEGRATED
HOSPITAL QUALITY ASSURANCE PROGRAM

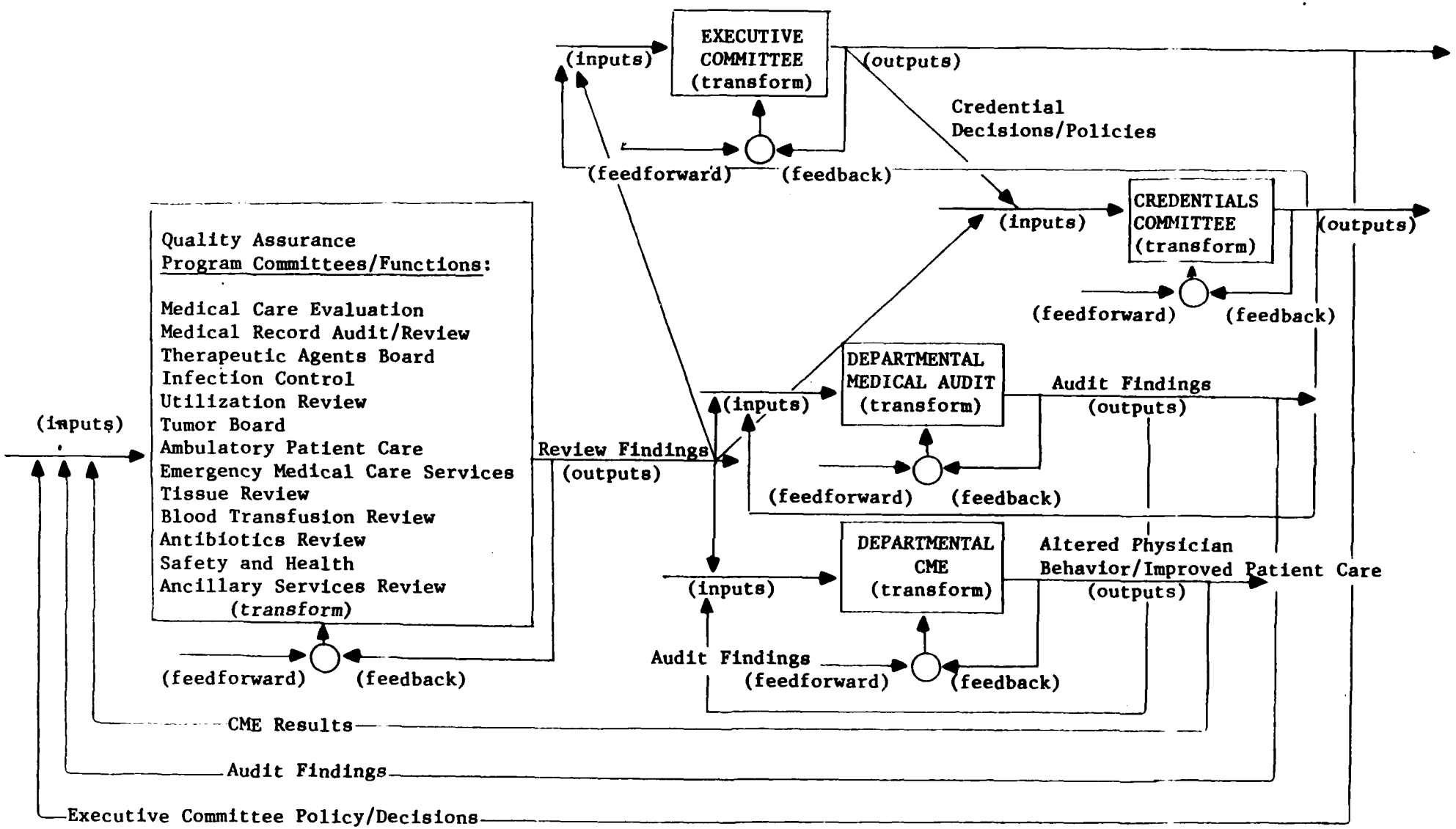


Figure 1

(Source: Allan R. Threet, "A Study to Determine the Optimum Feasible Plan for a Comprehensive Quality Assurance Program Integrated with a Continuing Medical Education Program at Santa Rosa Medical Center, San Antonio, Texas," A Health Care Systems Research Paper for the Health Care Administration Program, U.S. Army-Baylor University, Academy of Health Sciences Fort Sam Houston, Texas, 29 June 1979, p. 67.)

Problem Solving Methodology

This study will be conducted along four avenues. First, each Ireland Army Hospital committee will be analyzed as to its membership, attendance, meeting frequency and duration. A cost factor for each committee will be computed which will allow comparisons and contrasts between committees and between redesign alternatives. Second, each committee's interrelationship with other committees will be analyzed in an overall systems approach in order to determine where coordination exists and where it needs to be enhanced or initiated. Next, the AMEDD requirements and JCAH standards will be studied as they compare to the reality of the existing and redesigned committees structures.

Finally, the study will draw upon the expertise of the clinical and administrative staff of Ireland Army Hospital by employing a questionnaire. The questionnaire will primarily address the three issues previously identified: committee personnel costs, committee coordination effectiveness, and satisfaction of appropriate standards. In addition, the questionnaire will solicit input from the staff regarding committee management procedures which may enhance their effectiveness.

Upon completion of the analysis of the above-described approaches to the problem, alternative committee structures will be described and evaluated against the established criteria. The study will be concluded with a recommendation for the optimum feasible committee structure for Ireland Army Hospital.

FOOTNOTES

[1]U.S. Comptroller General, Report to the Congress of the United States; Military Medicine is in Trouble: Complete Reassessment Needed, HRD 79-107, 16 August 1979, p. i.

[2]Ibid.

[3]Health Services Command Ambulatory Patient Care Model #1, "A Central Appointment System," July 1974.

[4]Health Services Command Ambulatory Patient Care Model #18, "Clinical Support Division," 1 October 1977.

[5]Ibid.

[6]Alan D. Bauerschmidt, "The Hospital as a Prototype Organization," Hospital and Health Services Administration, Vol. 15 (Spring 1970), pp. 6-14.

[7]Duncan Neuhauser, "The Hospital as a Matrix Organization," Hospital and Health Services Administration, Vol. 17 (Fall 1972), p. 19.

[8]L. Eugene Baldwin, "An Empirical Study: The Effect of Organizational Differentiation and Integration on Hospital Performance," Hospital and Health Services Administration, Vol. 17 (Fall 1972), p. 64.

[9]John E. Affeldt, "Quality Assurance Standard Issued," Hospitals, (16 December 1979), p. 15.

[10]Joint Commission on Accreditation of Hospitals 1980 Accreditation Manual for Hospitals, "Quality Assurance," p. 154.

[11]Signe S. Cooper, "Committees That Work," Journal of Nursing Administration (January-February 1973), p. 31.

[12]Ibid.

[13]Anthony Jay, "How to Run a Meeting," Harvard Business Review, Vol. 54 (March-April 1976), p. 43-4.

[14]Bruce Kemelger, Assistant Professor, University of Louisville, Lecture to Fort Knox, KY, Ireland Army Hospital staff, "Decision Making in Health Care Organizations," 20 November 1979.

[15]William H. Newman and James P. Logan, Strategy, Policy and Central Management, (Chicago: South-Western Publishing Co., 1971), p. 412.

[16]Angelos A. Tasklanganos, "The Committee in Business: Asset or Liability?," Personnel Journal (February 1975), p. 90.

[17]Van McGraw, "It's Not the Committee. It's How You Use It," Hospital Financial Management (February 1979), p. 24.

[18]Tasklanganos, p. 90.

[19]McGraw, p. 24.

[20]Newman and Logan, p. 413.

[21]McGraw, p. 24.

[22]Joseph D. Cooper, How to Get More Done in Less Time, (Garden City, N.Y.: Doubleday and Company, Inc., 1971), p. 273.

[23]Ibid.

[24]Jay, p. 43.

[25]Tasklanganos, p. 91.

[26]Newman and Logan, p. 412.

[27]Ibid, p. 413.

[28]Frank C. Spencer, "Observations on the Functioning of Committees," Surgery Vol. 78 (September 1975), p. 395-6.

[29]Jay, p. 47.

[30]Tasklanganos, p. 91.

[31]Newman and Logan, p. 413.

[32]McGraw, p. 24.

[33]"Learning the Ropes as a Committee Chairman," Trustee (Septembe 1979), p. 32.

[34]Tasklanganos, p. 91.

[35]Theodore Caplow, How to Run Any Organization, (NY: Holt, Rinehart and Winston, 1976), p. 58.

[36]Signe S. Cooper, p. 32.

[37]Ibid.

[38]A. G. W. Whitfield, "How to Chair a Committee," British Medical Journal, (30 September 1979), p. 936.

[39]Tasklanganos, p. 91-92.

[40]McGraw, p. 25.

[41]Richard E. Thompson," Some Keys to Working with Physicians," Trustee (November 1979), p. 35.

[42]Thompson, p. 35.

[43]JoAnn Grozuczak and George A. Olander, "A Problem-Oriented Approach to Medical Staff Committee Structure," The Hospital Medical Staff (November 1974), p. 14.

[44]Curt Lindberg, "Realign Committee Structure That Perform Medical Staff - Hospital Functions," Hospitals Vol. 50 (1 August 1976), p. 90.

[45]John M. Mancano, "Handbooks Simplify, Improve Committee Work," Hospitals, Vol. 46 (16 December 1972), p. 49-50.

[46]Tasklanganos, p. 91.

[47]Jay, p. 49.

[48]Ibid.

[49]Signe S. Cooper, p. 31-32.

[50]Sandra L. Gill, Lecture to the 23d Congress on Administration, American College of Hospital Administrators, "Managing Meetings For Results," 20 February 1980.

[51]Signe S. cooper, p. 31-32.

[52]Tasklanganos, p. 91.

[53]"Learning the Ropes as a Committee Chairman," p. 32.

[54]Spencer, p. 397.

[55]C. Richard Decker and Ross H. Jackson, "How to Make Committees More Effective," Management Review (February 1976), p. 36-7.

[56]McGraw, p. 25.

[57]Ibid.

[58]Kemelgor.

[59]McGraw, p. 25.

[60]Signe S. Cooper, p. 33.

[61]Richard J. Dunsing, "Cure for the Dull Meeting: Careful Planning," Health Services Manager, Vol. 11 (September 1978), p. 3.

[62]Edwin C. Bliss, Getting Things Done, (NY: Bantam Books, 1978), p. 88.

[63]"Learning the Ropes as a Committee Chairman," p. 33.

[64]Signe S. Cooper, p. 32-33.

[65]Jay, p. 50.

[66]Whitfield, p. 936.

[67]Ibid.

[68]Signe S. Cooper, p. 32-33.

[69]Whitfield, p. 936.

[70]Joseph D. Cooper, p. 274.

[71]Jay, p. 55.

[72]Dale Carnegie, How to Save Time and Get Better Results in Conferences, (Garden City, NY: Dale Carnegie and Associates, Inc., 1974), p. 8.

[73]Bliss, p. 90.

[74]Robert E. Scott, "Principles and Techniques of Time Management," Hospital Progress, (May 1978), p. 57.

[75]Jay, p. 55.

[76]Whitfield, p. 936.

[77]Dunsing, p. 3.

[78]Bliss, p. 90.

[79]Whitfield, p. 937.

[80]Frederick R. McLain, Assistant Professor, Baylor University, Lecture to U.S. Army-Baylor University Health Care Administration Graduate Program, "Toward a Definition of Quality," 5 April, 1979.

[81]Linda S. Hischke, "Evaluating the Quality of Health Care: A Coordinated Effort," Texas Hospitals, (December 1977), pp. 13-14.

[82]"The Board's Role in Risk Management," Trustee, (September 1979), p. 57.

[83]Ibid.

[84]Noel G. Smith, "A Systemwide Quality Assurance/Risk Management Program," The Hospital Staff, (August 1979), pp. 40-44.

[85]Steven L. Salman, "A Systems Approach Can Ensure High-Quality Care and Low Costs," Hospitals, (16 March 1979), pp. 79-82.

[86]Paul J. Sanzaro, "Medical Audit, Continuing Medical Education and Quality Assurance," The Western Journal of Medicine, Vol. 125 (September 1976), p. 251.

[87]"Worth Repeating: Questions on Quality Assurance," Perspectives on Accreditation, (September/October 1979), p. 10.

[88]"Worth Repeating: Questions on Quality Assurance," Perspectives on Accreditation, (November/December 1979), p. 5-6.

[89]John E. Affeldt, "Quality Assurance Standard Issued," Hospitals, 16 December 1979, p. 15.

[90]James W. Dietz and James L. Phillips, "The Quality Assurance Committee in the Hospital Structure," Quality Review Bulletin (January 1980), pp. 8-12.

[91]Richard E. Thompson, M.D., Quality Assurance Consultant, Lecture to Kentucky Peer Review Organization participants, "Audit/MCE Update; A New Perspective in Quality Assurance," Louisville, KY, 6 September 1979.

[92]"Worth Repeating: Questions on Quality Assurance," Perspectives on Accreditation, (November/December 1979), p. 5.

[93]Olga Dean, R.N., Field Representative, Hospital Accreditation Program, Joint Commission for Accreditation of Hospitals, Lectures to Fort Knox, KY, Ireland Army Hospital staff, "The New JCAH Quality Assurance Standard," 16 and 24 April 1980.

[94]Joint Commission for Accreditation of Hospitals Seminar on Quality Assurance, Nashville, TN, 28-29 February 1980.

[95]Joint Commission for Accreditation of Hospitals, 1980 Accreditation Manual for Hospitals, Quality Assurance Standard, pp. 151-54, 208-209.

[96]Thompson, 6 September 1979.

[97]Dean, 16 and 24 April 1980.

[98]Joint Commission for Accreditation of Hospitals Seminar on Quality Assurance, 28-29 February 1980.

[99]Ibid.

[100]Salman, pp. 79-82.

[101]Smith, pp. 40-44.

[102]Joseph B. Davis and Barry S. Bades, "The Systems Approach to Patient Safety," Quality Review Bulletin, (February 1979), pp. 17-21.

[103]Alan R. Nelson, "Peer Review and CME: Closing the Loop," The Hospital Medical Staff, Vol. 6, (March 1977), p. 19.

[104]Allan R. Threet, "A Study to Determine the Optimum Feasible Plan for a Comprehensive Quality Assurance Program Integrated with a Continuing Medical Education Program at Santa Rosa Medical Center, San Antonio, TX," a Health Care Systems Research Paper for the Graduate Health Care Administration Program, U.S. Army-Baylor University, Academy of Health Sciences, Fort Sam Houston, TX, 29 June 1979.

[105]Dietz and Phillips, pp. 8-12.

II. DISCUSSION

By virtue of their basic functions the committees at Ireland Army Hospital can be divided into two categories. One group of committees has in common the responsibilities for planning, programming, evaluating and conserving the resources of the hospital. For the purposes of this study these committees will hereafter be referred to as the Resources Management Committees (RMC). The second group of committees has as their primary emphasis the responsibilities for planning, evaluating and improving the quality of patient care delivered at Ireland Army Hospital. These committees will hereafter be identified collectively as the Quality Assurance Program Committees (QAPC). The individual committees which comprise these two classifications will be identified and more fully examined later in the study.

The discussion will conduct a complete analysis of the hospital committees within the larger two categories. Committee analysis will utilize the three criteria previously identified, i.e., cost, coordination and integration and satisfaction of AMEDD requirements and JCAH standards. A committee cost factor has been computed for each committee to be studied. This factor is utilized as a simple guage by which the committee may be compared and further analyzed. It is not

intended that the committee cost factor represent an exact dollar figure. Appendix B explains the basis for the committee cost factor. The cost factor for each committee is derived from the required membership, the current ranks and grades of its members, and the frequency and the usual duration of the committee's meetings. Following the complete analysis of the two categories of committees will be presented a report on and an analysis of the questionnaire which was completed by the administrative and clinical staff of Ireland Army Hospital. Finally, the hospital committee structure alternatives will be proposed and evaluated.

Committee Analysis

Resources Management Committees

Appendix C provides a list of the RMC's as well as a Committee Analysis Sheet on each committee within this category.

Current organization

The current organization structure of the eight RMC's at Ireland Army Hospital is depicted at Appendix D. This chart is derived from MEDDAC Regulation 15-1, "Boards, Councils and Committees," with Change 1 dated 5 February 1980. The RMC patterns of communication indicated on the chart reflect those reporting mechanisms which are described in the individual committee appendices of MEDDAC Regulation 15-1. Also provided at Appendix D is a matrix chart which depicts the Ireland Army Hospital staff members who serve on each RMC.

Cost analysis

On the basis of the individual committee cost factors the average annual personnel cost for the operation of the RMC's within the current structure totals $8,297.00. It is recognized that this is not an exact figure. While some committees will not meet as frequently as required, others will meet more frequently. Additionally, this total does not account for personnel absences, promotions, tardiness, commuting time to and from each meeting, long and short meetings, etcetera. However, this figure does represent a considerable expense to Ireland Army Hospital for personnel costs and loss of workload due to attendance at committee meetings. Therefore, it is important that the RMC's are properly staffed, organized and efficiently operated.

Meeting frequency

Analysis of the RMC's reveals that all committees are generally meeting as frequently as required. Exceptions include the Position Management Review Team (PMRT) and the Automation Guidance Council (AGC). The PMRT is, according to MEDDAC Regulation 15-1, required to meet weekly. However, PMRT minutes are not available to document this fact. Instead, it is felt that the PMRT is more of an informal consultative mechanism for decision-making among staff members. The AGC is a relatively new committee yet to fully discover its utility within the RMC structure.

Meeting duration and attendance

Analysis of RMC's meeting durations reveals nothing

remarkable. The RMC's are generally well-organized and well-controlled meetings. Committee liaison such as the Working Program Budget Advisory Council (WPBAC) is a significant factor in the management of such a large, essential function as the Program Budget Advisory Committee (PBAC). Attendance of RMC's does not appear, upon review of the minutes, to be an issue which might inhibit committee performance. While room for improvement in the area of decreasing individual committee member tardiness is apparent, it is not of a serious nature.

Committee membership

Perhaps the most significant cost analysis feature within the RMC group is committee membership. There are several examples of duplicated organizational activities on RMC's. Examples include the MEDDAC Engineer Review Board (MERB) and the Energy Conservation Tast Group (ECTG) where the Chief of Logistics Division and the Chief of Service Branch are both members. The MERB has a total of four Logistics Division staff members assigned. Correction of such duplicaton by appointing as members only one or at most two staff members from the same activity could result in significant savings. Other staff members whose expertise may be required on the committee could be appointed as consulting members and notified when their presence is required. Generally, the RMC's specify that in the member's absence alternates are required to attend meetings.

Coordination and integration

There are several areas where RMC effectiveness and efficiency could be enhanced by improved coordination and integration. Perhaps the most significant area involves the two major committees of the RMC's, the PBAC and the Review and Analysis Committee (R&A). The PBAC's primary mission is to advise the Commander regarding the priorities of future allocations of personnel, financial and materiel resources. On the other hand, the purpose of the R&A is to advise the Commander of the current status and historical trends of those same resources, utilizing locally-developed and higher headquarter's yardsticks for comparative analysis. Given these two committee functions and their overlap the necessity for closer coordination becomes apparent.

Another instance exists where the R&A could enhance the effectiveness of an RMC occurs with the PMRT by more direct coordination of minutes and statistical trends regarding workload and staffing. Quantitative information such as this should be the primary basis for decision-making and problem-solving in the realm of position management review.

Two RMC's possessing information which could enhance the performance of the PBAC are the MERB and the AGC. While the membership of these three committees overlaps somewhat, the routing of MERB and AGC minutes for review at PBAC meetings or even WPBAC meetings could establish a more sound foundation upon which PBAC priorities could be established.

Satisfaction of AMEDD requirements and JCAH standards

Generally speaking, the RMC's achieve their AMEDD requirements satisfactorily. Areas which might be improved include additional emphasis of historically minor committee functions and increased intercommittee coordination as discussed above.

The PBAC has been assigned a responsibility to which little effort has thus far been dedicated. This is the responsibility for the "...review, coordination of, and recommendations relative to... The use of building space and alteration of facilities, to include both minor construction and MCA proposals."[1] In view of the pending completion of Ireland Army Hospital's renovated first floor clinic and administrative areas and the many associated clinical and administrative relocations which will soon follow, this is indeed fertile ground for committee action.

Though applicable to RMC's, the JCAH standards are so general and inconclusive to a military treatment facility that there are no mandates above those which the AMEDD and Army already impose.

Quality Assurance Program Committees

Appendix E provides a list of the QAPC's as well as a Committee Analysis Sheet on each committee within this category.

Current organization

The current organization structure of the fifteen

QAPC's at Ireland Army Hospital is depicted at Appendix F. This chart is derived from MEDDAC Regulation 15-1. QAPC patterns of communication indicated on the chart reflect those reporting mechanisms which are described in the individual committee appendices of MEDDAC Regulation 15-1. Also provided at Appendix F is a matrix chart which depicts the Ireland Army Hospital staff members who serve on each QAPC. In the technical sense the Executive Committee and the Utilization Review Committee (URC) represent both the resources management and the QAPC categories. However, for the purposes of this study they will be considered in the QAPC classification.

Cost analysis

On the basis of the individual committee cost factors the average annual personnel cost for the operation of the fifteen QAPC's within the current structure totals $35,385.00. Without the daily, high-powered Executive Committee and the fictitious centralized URC, the QAPC total is $12,887.00. It must be emphasized that this dollar figure does not include the hospital's loss of workload in the form of patient visits and episodes of surgery which could have been accomplished had the health care provider personnel and their clinical and administrative support personnel been delivering direct and indirect patient care in clinics, on wards and in operatories. The other shortcomings of this cost factor guage have previously been explained. This calculation of a hospital's investment in committee management

for quality assurance purposes does, however, serve to emphasize the necessity for an effective and efficient committee structure and associated administrative procedures.

Meeting frequency

Analysis of the QAPC's reveals that all committees are generally meeting as frequently as required either by the AMEDD or the JCAH accreditation standards. Exceptions include the Executive Committee, which documents daily meetings instead of monthly meetings, and the decentralized URC, which has delegated its functions to six other QAPC's. While HSC Pamphlet 40-1 allows for such a delegation of utilization review functions to existing committees, it specifies that the delegated committees must meet monthly.[2] This, in fact, is not the case. One QAPC which has held no meetings, without the benefit of formally delegating its functions, is the Hospital Accreditation Committee (HAC). The HAC has allowed its functions to be carried-out by individual staff members without the benefit of documentation and formal reporting mechanisms. While the HAC may justify its inactivity by asserting that the Executive Committee has discharged its responsibilities, this is only partially accurate.

There are three other committees and one committee function which exceed the requirements for meeting frequency. The Infection Control Committee (ICC) meets monthly in accordance with MEDDAC Regulation 15-1. Paragraph 2-5b of Health Services Command Pamphlet 40-1 specifies an appropriate

ICC meeting frequency of "...not less than every other month."[3] The Therapeutic Agents Board (TAB), which meets monthly, exceeds the quarterly meeting guidance of Health Services Command.[4] At least quarterly is the official minimal requirement for the Ambulatory Patient Care Committee (APCC), which also convenes on a monthly basis.[5] One function which need not be addressed by a separate committee is medical records review. This function is required on a quarterly basis[6] and yet is accomplished by the Medical Care Evaluation Committee (MCEC) each month.

It is not proposed that productive employment of committees with their current meeting frequency practices should be interrupted. However, each of these committee chairpersons should lead his or her committee through a serious analysis of the impact upon committee productivity by less frequent meetings. The personnel cost savings, which would result, are only significant, if the committee's mission accomplishment would not be jeopardized.

Meeting duration and attendance

Perhaps the most time-consuming of the QAPC's are the Credentials Committee, the MCEC and the TAB. Each of these committees' meetings have been known to exceed two hours at one point or another. The attention to detail required in each of these committees, coupled with the magnitude and importance of their responsibilities, necessitates extremely careful planning and preparation on the part of the chairperson and recorders.

Attendance is a problem for each of the QAPC's. On-call schedules, emergency surgeries, overloaded outpatient clinics and simple forgetfulness contribute to delayed and ineffective meetings. Selection of and adherance to a specific month, week, day, time and location could play a significant part in improving a committee's effectiveness by allowing physicians and others to schedule patients and other activities around the pre-established meeting. The committee recorder's efforts to notify and remind members by hospital daily bulletin announcements, overprint Disposition Forms, personal telephone calls and public address announcements can also reduce absenteeism and tardiness. Perhaps the QAPC's most frequently affected by poor attendance have been the Medical Record Audit Committee (MRAC), the Tumor Board and the MCEC. It is essential that this problem be addressed and alleviated by the chairpersons, recorders and members of those committees.

Committee membership

QAPC's range in membership size from the tiny Rabies Advisory Board to the enormous APCC. The mean number of members in QAPC's is eleven. It is not practical to adhere to the literature's recommendation for the ideal committee size of five staff members.[7] The hospital's matrix organization requires additional personnel to be present, if not for their expertise, then for their responsibility to communicate the actions of the committee to their department or division colleagues. This fact places even more pressure on the committee

chairperson. Realizing the difficulty of managing and leading under ideal circumstances, the QAPC committee chairpersons have an awesome task to manage and lead under such adverse conditions. At this point the careful selection of committee members and particularly of chairpersons becomes imperative. Unfortunately, the existing organizational hierarchy of leaders by virtue of their rank and position within the MTF inhibits the selection process which is so sorely needed.

Some QAPC's have leverage in regard to committee size due to their built-in duplicity. One example is the Radiation Control Committee (RCC) where both the Radiation Protection Officer (RPO) and the Alternate RPO serve with the Chief of the Department of Pathology and two of his subordinate section chiefs.

A membership problem occurs in three separate committees where the committee chairperson's own supervisor and rater serves as a member of his or her committee. The literature discourages subordinates and supervisors even serving together.[8] But, a subordinate to lead a superior in the management of a committee seems to be asking too much. The three committees referenced here are the ICC, the Safety and Health Committee and the APCC.

Coordination and integration

As depicted in the current organization chart for the QAPC's at Appendix F there are significant shortcomings in the area of committee intercommunication. MEDDAC Regulation

15-1 reveals five QAPC's which do not report on their activities at all, while one committee reports its activities to three different agencies. In reality, all QAPC's activities are reviewed by the Executive Committee. However, the QAPC structure for sharing its work, information and recommendations needs to be enhanced.

An example of an AMEDD requirement for intercommunication which is currently not accomplished is the APCC and the Emergency Medical Care Services Committee (EMCSC). HSC Pamphlet 40-1, paragraph 2-15e, outlines the APCC's responsibility to review the EMCSC's minutes.[9] This same publication also requires that a liaison be established between the ICC and the Safety and Health Committee.[10]

The new JCAH QA standard has an influence on the QAPC integration and coordination issue. Under the comprehensive, integrated QAP criterion there is the requirement for a QA plan which demonstrates the QAP organizational structure and its interdependencies.[11]

Satisfaction of AMEDD requirements and JCAH standards

The QAPC's are generally in compliance with AMEDD and JCAH criteria for their various functions. Improvement of intercommunications on the part of four committees as previously discussed would satisfy the AMEDD requirements with the QAPC.

Potential for JCAH standards noncompliance exists with

one QAPC, the Medical Record Audit Committee (MRAC). The new JCAH QA standard has significantly modified the ground rules under which the MRAC has been functioning. While the new standard offers numerous options for patient care evaluation studies, it is paramount that the MRAC begin to follow the problem-focused, prioritized method of conducting and documenting quality assurance review.

Committee Questionnaire Analysis

Both the clinical and administrative staffs of Ireland Army Hospital were polled concerning the existing hospital committee structure and its associated procedures. Appendix G represents a copy of the original survey tool which was utilized. The following discussion will analyze the hospital staff's questionnaire responses.

Demographic Information

Questionnaire respondents

In March of 1980 the Ireland Army Hospital Committee Questionnaire was distributed to forty-five key members of the staff. A seventy-six percent successful return rate was experienced. There were a total of thirty-four respondents of whom fourteen percent were colonels, 0-6, forty percent were lieutenant colonels, 0-5, thirty percent were majors, 0-4, seven percent were captains, 0-3, and seven percent were civilians, grades GS-11 and GS-7. Within the group of thirty-two military respondents are represented the opinions of fourteen Medical Corps officers, eleven Medical Service

Corps officers, six Army Nurse Corps officers and one Army Medical Specialist Corps officer.

Committee membership

Of the questionnaire respondents seventy-one percent reported membership on more than one committee. It should be noted here that the questionnaire respondents listed departmental and divisional committees and various other meetings which are beyond the limitations of this study. Thirty-five percent listed membership on five or more committees. One respondent in the grade of 0-6 listed membership on sixteen committees and meetings. Only one respondent reported membership on no committees. That same individual emphatically expressed a preference for continuation of that condition.

Duration of membership

An important feature in the analysis of a committee and its effectiveness is knowledge about the length of time in which committee members have served. It was extremely enlightening to learn that fifty-three percent of the staff surveyed, who answered their questionnaires, claimed membership on committees for less than one year. Only eighteen percent had served as members for two years and only fifteen percent had served for three years or more.

Committee positions

Twenty-four percent of the questionnaire respondents serve as committee chairpersons. Fifteen percent serve as committee recorders.

Transition time

Transition time, for the purposes of this study, will represent the average amount of time required for a committee member to commute from his or her work site to and from the location of the committee meeting. Almost one-half, forty-seven percent, of those polled reported their transition time to be less than five minutes, while thirty-eight percent indicated experience with between six and fifteen minutes transition time. Only twelve percent cited their transition time as between sixteen and thirty minutes. This last group consisted of Ireland Army Hospital staff members whose work sites are outside of the main hospital area. One of these respondents mentioned that official questions and unofficial delays following committee meetings contribute to lengthy return transition times.

Membership and Committee Functions

Membership functions

Forty-one percent of those polled stated that they had been briefed as to their committee responsibilities. Those who claimed no education as to their committee responsibilities, fifty-nine percent, cited their own familiarization efforts as the sole means of orientation to their committees. Some of these individuals listed their sources of committee orientation to be local and AMEDD Regulations and other pertinent written references.

Committee functions

There was a similar response as regards the committee

member's orientation to the mission or purpose of their committees. Thirty-eight percent stated that they had been given an indication of their committee's functions. Those who did not receive an orientation as to their committee's mission totalled sixty-two percent.

Committee effectiveness

Despite the "ill-defined goals for some committees" claimed by one respondent, an over-whelming majority, seventy-one percent, stated that the committees on which they served were effective in accomplishing their missions. The balance stated that their committees "sometimes" were effective, were "redundant," or were in need of consolidation. One respondent cited a disadvantage of management by committee which has already been mentioned in the literature review. The disadvantage is that while committee's missions often are to recommend alternative actions, committees are basically powerless to implement or enforce their recommendations.

Improvements in Committee Management

Membership selection

Question number eight asked the staff their opinions about Ireland Army Hospital's current policy for membership selection based on a person's position. Fifty-three percent stated that a committee's membership should be determined by position. Those who claimed that committee membership based upon heirarchial assignment had "some merit" totalled seventeen percent. Thirty percent disagreed. Variables which this group felt should determine committee membership included

a person's personality or interests and organizational turnover in general.

Alternative methods of committee membership selection were offered in question number nine. These included: appointment by position, appointment by supervisor based on the individual's interests or preference, and election by peers. The twenty-six respondents to this question overwhelmingly, sixty-five percent, identified committee membership selection by position as their preference. Their response was justified by the committee member's need for authority to make decisions. Twenty-seven percent endorsed selection on the basis of an individual's interests or preference. Some respondents recommended a combination of position and interest determinants. One answer simply recommended that "...workers, not just bosses..." be appointed to committees.

Committee improvements

Two questions addressed committee improvements. Question number six generally asked for suggestions which might cause committee management to be enhanced. Twenty-one percent stated that no changes were necessary to improve committee management. A decrease in meeting frequency was cited by twelve percent, while an increase in meeting frequency was cited by six percent. The one committee, which one staff member felt ought to meet more frequently, was the Therapeutic Agents Board. Two respondents recommended that a meeting not considered in this study, the Commander's Combined Staff Conference, be held twice per month instead

of monthly. Improved committee meeting attendance was suggested by twelve percent of the respondents. Other committee management suggestions included combination of committees with overlapping missions, nine percent, distribution of agendas prior to meetings, six percent, and standardization of committee input via charts, three percent.

Question number fourteen posed the same issue in a different manner by asking the staff what committee management policies they would observe were they to serve as committee chairpersons. Ninety-three percent stated that committee meeting attendance would be compulsory, while the remaining seven percent expressed that they would "encourage" attendance. Of those who responded, seventy-one percent preferred that members with excused absences send a representative to their meetings. One respondent gave a qualification for the member's alternate by stating that the alternate must be an informed representative.

Means of member preparation for meetings preferred by sixty-eight percent included reading previous minutes or review of the future meeting agenda. Utilization of meeting agendas was preferred by eighty-eight percent. Several staff members suggested that the agendas be distributed to the membership in advance. One staff member further refined the agenda's function by recommending that a time schedule be indicated next to each agenda item in an effort to conserve time. A unanimous preference was expressed for committee minutes. Minutes should be: brief and concise; completed

within a specified number of duty days of the meeting; distributed soon after the meeting; and specific as to action responsibilities and suspense requirements.

Only eleven percent of the staff expressed a preference for delaying a committee meeting for its tardy members. The remaining eighty-nine percent not only stated that as chairpersons they would start on time, but some stated that they would embarrass or "lock-out" those committee members who were late for a meeting. A suggestion was made that those persons who were chronically late should be appropriately disciplined within command channels. It is interesting to note that the eleven percent who expressed tolerance of late-comers were 0-5 and 0-6 Medical Corps officers.

Other interesting suggestions for improvement of committee management were offered. One emphasized the necessity for the committee chairperson to maintain control of the committee meeting. Another suggestion was for the chairperson to keep the committee meeting on schedule to minimize the wasting of time and maximize the committee's productivity. Limiting the committee size to the minimal essential staff and consideration of the room size of a meeting's location were other points of concern. Finally, one staff member recommended that the rules of attendance, representatives, quorums, and timeliness be clarified in MEDDAC Regulation 15-1.

Scheduling of committee meetings

Several questions within the survey addressed alternatives for the scheduling of committee meetings. These

alternatives included scheduling meetings as the primary function for one or two days per month and scheduling meetings to coincide with meal times.

"Marathon" meetings

Blocking-out patient appointments, surgery schedules and all other business for one or two days per month in order that the majority of the hospital's committee business may be conducted might be labelled as the "marathon" meeting proposal. The staff's opinion of this proposal was markedly split with sixty-one percent in favor and thirty-nine percent against. Analysis of the questionnaire's responses reveals that preferences by branches of service were comparable. For example, of those in favor forty-seven percent were Medical Corps officers, thirty-five percent were Medical Service Corps officers and Army Nurse Corps officers totalled eighteen percent. Of those against the proposal, the Medical Corps officers represented fifty-five percent. Twenty-seven percent and eighteen percent were Medical Service Corps officers and Army Nurse Corps officers respectively. Two Medical Corps officers cited their stand against marathon meetings. One claimed that two days of meetings per month would be unbearable. The other reported the failure of a similar exercise at another MTF. Assuming that a marathon meeting day were to be attempted, the staff preferred the third week of the month by forty-one percent and the second week by twenty-four percent.

Mealtime meetings

When asked about scheduling meetings to coincide with meal times the staff again had a definite split in preference: thirty-six percent were in favor and sixty-four percent were against. Those in favor of the proposal justified their preference by claiming a savings of time. One Medical Corps officer allowed that more patients could be seen by such a scheduling procedure. Justifications given by those not in favor of meeting and eating included the following: interference with personal business such as jogging, errands or diets. The branches of service were again comparably aligned in that of those in favor of the proposal the percentage of Medical Corps officers equalled that of Medical Service Corps officers. Medical Corps officers against the proposal were slightly higher, forty-three percent, than the Medical Service Corps group, which had thirty-eight percent.

Assuming that meetings were to be scheduled at meal times, those few staff members who recorded a preference indicated that lunchtime was the most preferred with seventy-seven percent. Breakfast got only twenty-three percent. No staff members chose dinner time.

Coordination and integration

The staff's feedback in this portion of the questionnaire was disappointing. Forty-one percent of the respondents either had no comment or no ideas regarding the hospital's committee structure and improvement of its integrative

mechanisms. Functionalization was suggested by twelve percent as a means to correct the committee structure's shortcomings. A consolidation of committees was suggested by six percent. Other suggestions included the following: establish a committee to study the problem; convene a meeting of all committee chairpersons to discuss the matter; and, assign more administrative staff members as committee chairpersons. Some particularly revealing comments included "...too often we make decisions in a vacuum..." and there is "...no solution to the problem."

QAP and committees

The staff's response to the questionnaire's last inquiry regarding the new JCAH QA standard and its requirement for a comprehensive, integrated QAP was also below this analyst's expectations. Of the thirty-four respondents only sixty-five percent entered a reply to this question. Twenty-seven percent of those recorded their basic unfamiliarity with the existing QA Program. Variations of a proposal for establishing a coordinating QA Committee were made by thirty-two percent, while one staff member suggested assignment of two fulltime officers as QA Coordinators.

Alternatives and Evaluations

Consideration of alternative solutions to the hospital's committee structure will be sub-divided into the two categories of committees, RMC's and QAPC's. Each alternative will be described and evaluated against the three pre-established

criteria. Appendices H and I represent decision matrixes for the alternatives in each committee category.

Resources Management Committees

Alternatives and Evaluation

RMC Alternative One

The first RMC alternative for consideration is to accept the current RMC organizational structure without modification. Appendix D depicts the current structure. While it must be considered an option, RMC Alternative One is not viable. The duplication of committee members, the overlap of committee functions and the general lack of effective integration and organization render RMC Alternative One less than desirable.

RMC Alternative Two

The second alternative for improvement of the hospital committee structure addresses the committee reporting or integrative mechanisms. By altering the routing procedures of minutes between and among RMC's, the potential for greater integration and coordination will be enhanced. Specific examples where RMC Alternative Two may be employed follow.

The Program Budget Advisory Committee's (PBAC) review of Review and Analysis (R&A) minutes could significantly improve its problem-solving and decision-making capability by virtue of the availability of qualified workload, staffing and supply data. Reciprocal review of PBAC minutes by the R&A would enable that body to interpret whether or not the

PBAC had adhered to the Commander's guidance for priorities and direction of effort. Review of minutes from the MEDDAC Engineer Review Board (MERB), the Automation Guidance Council (AGC), the Energy Conservation Task Group (ECTG) as well as the Position Management Review Team (PMRT) and the Civilian Training Committee (CTC) would enable the PBAC to be fully aware of the current policies, procedures, and priorities for utilizaton of building space and automated data processing, consumption of energy, and the placement and training of personnel. The receipt and review of R&A minutes by the MERB, the PMRT and the AGC could also provide more consistent priorities and direction of effort for these committees.

Analysis of the effects of RMC Alternative Two reveals that greater committee integration and coordination would enhance the committee's effectiveness and, therefore, their satisfaction of AMEDD requirements and these few applicable JCAH standards. However, the increased amount of committee meeting time which would be consumed in review of minutes from other RMC's would have an adverse effect upon the RMC's cost factor.

RMC Alternative Three

RMC Alternative Three primarily concerns itself with the maximization of the committee cost factor by reduction of committee members' transition time. This alternative would provide for a programmed consolidation of committee meeting schedules by means of a "marathon" meeting format. Specific examples follow.

Since the memberships of the R&A and the PBAC are so similar, it is proposed that these committees meet on the same day with a few minutes between adjournment of one and convening of the other. This would allow non-members of the second committee to be excused and members of the first committee to take a short break. This concept could apply also to the MERB and the ECTG. It may even be considered appropriate for non-committee meetings such as the Executive Officer's Administrative Staff Meeting or the Commander's Combined Staff Conference to be included within this consolidation of committee meeting schedules.

Evaluation of this alternative reveals disadvantages and advantages. One disadvantage is the difference in the committees' frequency of meeting. The R&A and the MERB are currently monthly meetings while the PBAC and the ECTG meet quarterly. Another disadvantage is the potential loss of committee members' attention due to prolonged meetings.

Advantages of RMC Alternative Three include maximization of the staff's productive time by minimizing the existing transition time. With meetings held in sequence, the transition time for members can be reduced by a factor equal to the number of meetings in sequence. Consolidation of committee schedules indirectly improves committee integration and coordination by allowing committee members to immediately pass from the business of one committee into that of another. This enhanced integration occurs without the necessity for time-consuming review of committee minutes.

RMC Alternative Four

The fourth alternative for improvement of the RMC's proposes a consolidation of committees by function. Within this alternative are innumerable options for consolidation. What is deemed to be the optimum RMC consolidation structure is described below.

Membership congruence and the resources analysis and assignment missions of the R&A and the PBAC naturally lend themselves to consolidation. Following the R&A's presentation of the command's current resource status and the Commander's guidance on future priorities, the decision-making mission of the PBAC would be simplified. The R&A would become the direct driving or guiding force for the decision-making processes of the PBAC. The Commander would be a consulting member of the R&A/PBAC chaired by the Executive Officer. Upon completion of the R&A presentation and the Commander's comments, the Commander would excuse him or herself from the consolidated committee meeting in order that its PBAC-related business may be pursued.

Within the realm of the management of resources the R&A/PBAC's role would be expanded by adoption of three RMC's as sub-committees. In its basic function of planning and coordinating, the AGC is a natural offspring of the R&A/PBAC. The MERB functions of resource allocation for MEDDAC buildings and the ECTG's mission for energy conservation within those MEDDAC buildings lend themselves to a supporting role of the R&A/PBAC. It is possible that the MERB and ECTG might

even further be consolidated into one PBAC sub-committee.

One of the remaining three RMC's may also capitalize upon its general supportive role to the R&A/PBAC. This is the CTC. The final RMC's, the Military Awards Committee (MAC), and the PMRT, might best be sub-units of the existing Program Budget Advisory Executive Committee.

The consolidated R&A/PBAC would be retitled the Resources Management Committee with its Working and Executive sub-committees. An additional sub-committee would be created for the expressed purpose of expanding the coordination for space allocation and utilization, a currently undeveloped role of the PBAC.

One disadvantage apparent upon analysis of RMC Alternative Four is the variance of committee meeting frequencies. The R&A is currently a monthly information sharing and gathering exercise with a specifically reserved day, time and location. Meanwhile, the quarterly PBAC is subject to sudden funding authorizations, personnel policy changes and other such unplanned and often uncontrollable events. In addition, the recommendations of committees which now meet independently and have direct access to the Executive Committee will be delayed by their subordination to the Resources Management Committee.

Both of these disadvantages may be overcome without severely altering the mission and purpose of the consolidated RMC's. In the first, place, the R&A function of the newly established Resources Management Committee may maintain its

routine, scheduled presentation with only slight modification by adopting a bi-monthly routine. The PBAC function would, of course, also assum a bi-monthly meeting frequency. Bi-monthly R&A meetings would enable the staff more time to evaluate and implement the command guidance and program priorities. Secondly, the sub-committees of the new RMC could meet on bi-monthly schedules opposite their parent committee. Business which these sub-committees determine should not be held in abeyance pending a bi-monthly RMC meeting could be submitted to the Executive Resources Management Sub-committee, which would be authorized to report directly to the Executive Committee and the Commander.

The advantages of RMC Alternative Four are numerous. Not only will consolidation of RMC's cause personnel costs to be minimized by reduction of overlapping committee memberships but also by reduction of membership transition time. Enhanced integration and coordination of RMC's is an obvious result of RMC consolidation. Satisfaction of AMEDD requirements and applicable JCAH standards would be the natural offspring of the improved state of RMC integration. An additional benefit of this alternative would be the fact that the Hospital Executive Officer would not necessarily be required to chair the RMC sub-committee's such as the MERB, the ECTG and the AGC. Chairpersons for these RMC sub-committees could be selected on either a functional, position basis or on the basis of individual interests.

RMC Alternative Five

The final RMC alternative for consideration incorporates the beneficial aspects of the previous three alternatives. RMC Alternative Four's committee consolidation combined with the committee schedule consolidation of RMC Alternative Three and the integrative reporting mechanisms of RMC Alternative Two results in an RMC structure designed to maximize the productive time of the hospital staff, while simultaneously maximizing the integration and satisfaction of AMEDD and JCAH prerequisites within the entire RMC category.

RMC Alternative Five may be effected by the bi-monthly meeting of RMC sub-committees in a consolidated schedule one after the other. Transition time would be minimized and sub-committee integration would be achieved without the necessity for the formal review of sub-committee minutes. During the following month the main RMC would meet in order to consider the current status of the command, receive the Commander's guidance and directives, evaluate the recommendations of its sub-committees, and then conduct other appropriate business. The consolidated RMC created by Alternative Five would submit reports to the Executive Committee. These reports would represent comprehensive, integrated thoroughly-staffed recommendations for the optimal management of the entire scope of the hospital's and the MEDDAC's resources.

Quality Assurance Program Committee

Alternatives and Evaluation

QAPC Alternative One

The first QAPC alternative for consideration would be to accept the status quo without modification. Appendix F depicts the current QAPC organizational structure.

The deficiencies of the existing QAPC structure are numerous. Memberships of the committees are duplicative and often wasteful. Committees lack logical reporting and consultative mechanisms. Finally, AMEDD and JCAH criteria are not totally satisfied under the existing system as previously described in the QAPC analysis. QAPC Alternative One is not an acceptable option particularly in view of the new JCAH QA standard and its mandate for a comprehensive, entegrated QAP.

QAPC Alternative Two

QAPC Alternative Two addresses itself to the QAPC integrative mechanisms. Potentially, the QAPC's can achieve greater integration and coordintion by altering their reporting procedures. Specific examples of where QAPC Alternative Two may be employed follow.

Health Services Command Pamphlet 40-1 requires that the Safety and Health Committee (S&HC) and the Infection Control Committee (ICC) establish a liaison with each other in order to achieve a mutual exchange of information.[12] By reviewing each other's committee minutes these two QAPC's would be better informed and, therefore, better able to discharge

their responsibilities. A similar requirement of another QAPC is implied in the same Health Services Command publication when the functions of the Radiation Control Committee (RCC) are listed. This reference requires the RCC to review "...all reports of unusual occurrences and alleged overexposures."[13] By the RCC's review of the S&HC minutes and that committee's reciprocal review of RCC minutes there would effectively be created a closed loop whereby patient and staff accident and incident reports would be appropriately addressed and acted upon.

The review of committee actions within the QAPC realm of ambulatory care also has application for QAPC Alternative Two. In accordance with Health Services Command Pamphlet 40-1, the Emergency Medical Care Services Committee (EMCSC) would submit its minutes through the Ambulatory Patient Care Committee (APCC) to the Medical Care Evaluation Committee (MCEC).[14] The review of the actions of the EMCSC and submission of its own minutes to the MCEC would effectively integrate the ambulatory services of the hospital and allow the MCEC to appropriately be informed and to more effectively evaluate the quality of care delivered within the ambulatory care program.

The third phase of QAPC Alternative Two involves the initiation of reporting by three committees through the MCEC to the Executive Committee. These are the Tumor Board (TB), the Therapeutic Agents Board (TAB) and the Rabies Advisory Board (RAB). Historically, two of these three committees

have reported directly to the Executive Committee. The RAB did not formally report for any higher echelon review. Such by-passing of the MCEC has prevented that body from accomplishing its responsibilities as regards the review and evaluation of controlled drug utilization and tumor case review.

Phase four of QAPC Alternative Two would require certain QAPC's to provide input to the Credentials Committee for consideration in the evaluation of the credentials of health care providers. The MCEC would report noteworthy patient care evaluation studies and all unjustified variances discerned through those studies. Drug utilization review results of note would also be reported to the Credentials Committee by the TAB. The Credentials Committee would also begin reporting directly to the Hospital Commander in accordance with its many regulatory documents.[15]

QAPC Alternative Two's final phase would reactivate the Hospital Accreditation Committee (HAC). This committee would begin to monitor the status of the facility's compliance with JCAH standards and its preparedness for a JCAH on-site survey. The HAC would report directly to the Executive Committee. Information copies of its minutes would be distributed to the MCEC and other appropriate QAPC's.

Evaluation of QAPC Alternative Two reveals a conflict. The enhanced integration and coordination of committee effort, which simultaneously satisfies AMEDD requirements and JCAH standards, also has a negative effect on the overall

QAPC cost factor. The increased amount of committee meeting time consumed in the review of other QAPC minutes would not be insignificant.

QAPC Alternative Three

This third alternative for consideration in the improvement of the hospital committee structure applies the "marathon" meeting principle to committees with like memberships and missions. Specific examples follow.

The Medical Record Audit Committee (MRAC), already a supporting agency of the MCEC, would be scheduled earlier on the same day as the MCEC. MRAC business would be accomplished and immediately shared with the MCEC without the time-consuming review of committee minutes and with a minimization of transition time for those staff members who serve on both committees.

The EMCSC would also comply with its requirement to report to the APCC by meeting immediately prior to that committee. In a similar meeting schedule consolidation, the ICC, the S&HC and the RCC would also discharge their liaison missions.

One QAPC which would be particularly adaptable for QAPC Alternative Three's committee schedule consolidation would be the Medical Library Committee (MLC). This committee could easily preceed or follow the MCEC, the TAB, the Credentials Committee, or the MRAC. In fact, the MLC might even be considered as a subordinate function of the Chief of Professional Services' Weekly Chiefs' Meeting, an information-

sharing and gathering meeting not addressed in this study. Such a schedule consolidation would not only save committee members' transition time, but it could simultaneously expedite the consideration, approval and requests for additions to the Medical Library's holdings.

Disadvantages of QAPC Alternative Three include differences in committee meeting frequencies and potential difficulty in committee liaison without benefit of written formal committee minutes. Advantages include the improved committee integration and a reduction of committee member transition time.

QAPC Alternative Four

This QAPC alternative proposes the consolidation of committee functions or actual committees. Due to the magnitude of the missions of the QAPC's, consolidation of committee functions or actual committees is significantly more arduous than was the case with RMC's. While committee memberships are similar, the special functions of most QAPC's, coupled with specific AMEDD and JCAH prerequisites, render QAPC's extremely difficult to consolidate functionally. Some possible examples follow.

The medical record review function of the MCEC is one committee function which would be functionally adopted and performed by a subordinate committee, the MRAC. Under QAPC Alternative Four, the MRAC would, in fact, become a subcommittee of the MCEC performing its current functions and assuming the function of medical record review and forms

for those newly requested inpatient and outpatient medical records forms. The chairperson and members of the MRAC would be selected based on their interests and preferences, as opposed to the current selection procedure which emphasizes the member's position.

QAPC Alternative Four's principle of consolidation of functions and whole committees has already successfully been applied in the area of utilization review. The manner in which the decentralized Utilization Review Committee (URC) has delegated its functions to the QAPC's and departmental meetings is the epitomy of the spirit of QAPC Alternative Four. Shortcomings of the decentralized URC have been sufficiently addressed in the Committee Analysis Sheet at Appendix E.

Two QAPC's which could potentially be consolidated are the APCC and its subordinate committee, the EMCSC. Consolidation of these committees would comply with the regulatory requirements for their integration and coordination. The differences in these committees' meeting frequencies could be resolved. The APCC currently exceeds its quarterly meeting requirement by meeting monthly. The EMCSC is only required by Health Services Command Pamphlet 40-1 to meet "...on a regularly scheduled basis."[16] With bi-monthly APCC meetings and interspersed EMCSC meetings these two committees could accomplish their missions and achieve maximum integration. In the event of additional, interim business requirements for either of these QAPC's, a working or an executive sub-

committee could be established for each committee.

One QAPC which could accomplish its mission by functional consolidation with any of several other QAPC's is the MLC. This function could be satellited off of the MCEC, the TAB, or even a non-committee meeting such as the Chief of Professional Services' Weekly Chiefs' Meeting.

Analysis of QAPC Alternative Four confirms the barriers to QAPC consolidation. Advantages to the four consolidation proposals offered include personnel cost savings by membership consolidation, reduction of members' transition time, enhanced QAPC integration and satisfaction of AMEDD requirements and JCAH standards. Disadvantages to the specifics of QAPC Alternative Four include the scope of the missions of two of the consolidated committees, the APCC and its new sub-committee, the EMCSC. It is entirely possible that, while these two QAPC's require more coordination, their size and the magnitude of their missions and memberships may render them unmanageable as one consolidated committee.

QAPC Alternative Five

The final QAPC alternative for consideration incorporates the previous three alternatives. QAPC Alternative Four's committee consolidation in conjunction with QAPC Alternative Three's schedule consolidation and the integrative reporting mechanisms of QAPC Alternative Two creates a QAPC structure which not only conserves staff time, but successfully achieves what the JCAH would classify as a comprehensive, integrated QAP.

QAPC Alternative Five may be implemented by initially establishing the integrative reporting mechanisms described in QAPC Alternative Three. Next, the consolidated meeting schedules described in QAPC Alternative Three may become a matter of experiment. Finally, the consolidation of committee functions and committees themselves may be accomplished.

FOOTNOTES

[1]MEDDAC Regulation 15-1, "Boards, Councils and Committees," with Change 1, dated 5 February 1980, Appendix 8 to Annex B, PBAC, paragraph 5a(7), p. B-8-4 and -5.

[2]Health Services Command Pamphlet 40-1, "Committees, Boards and Functions," dated 29 January 1979, paragraph 3-2a, p. 3-1.

[3]Ibid, paragraph 2-5b, p. 2-5.

[4]Ibid, paragraph 2-7d, p. 2-8.

[5]Ibid, paragraph 2-15b, p. 2-16.

[6]Ibid, paragraph 3-5a, p. 3-3.

[7]Anthony Jay, "How to Run a Meeting," Harvard Business Review, Vol. 54 (March-April 1976), p. 434.

[8]Ibid.

[9]Health Services Command Pamphlet 40-1, paragraph 2-15e, p. 2-16.

[10]Ibid, paragraph 2-4e(5), p. 2-4.

[11]Joint Commission on Accreditation of Hospitals, 1980 Accreditation Manual for Hospitals, Quality Assurance standard, p. 151-154.

[12]Health Services Command Pamphlet 40-1, paragraph 2-4e(5), p. 2-4.

[13]Ibid, paragraph 2-13b(10), p.-15.

[14]Ibid, paragraph 3-6e, p. 3-4.

[15]Ibid, paragraph 2-6g, p. 2-6.

[16]Ibid, paragraph 3-6b, p. 3-3.

III. CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The problem was to determine the optimum feasible committee structure for Ireland Army Hospital which would maximize the staff's productive time in a comprehensive, integrated manner while satisfying AMEDD requirements and JCAH standards.

The optimum feasible solutions for the committee structure of Ireland Army Hospital will be described within the two categories of hospital committees.

Optimum Feasible
Resources Management Committee
Structure

RMC Alternative Five is the optimum feasible committee structure for the RMC's within Ireland Army Hospital. Appendix J depicts the RMC optimum feasible solution.

The three committee analysis criteria are exceeded by the proposed RMC structure. Ireland Army Hospital's RMC membership cost factor is maximized by consolidation of committees, committee functions and schedules. The RMC structure's integrative reporting mechanisms significantly enhance the coordination between the RMC's. By virtue of its maximized, integrative efforts the RMC structure exceeds

both AMEDD requirements and JCAH standards. The proposed RMC structure represents a comprehensive, integrated and exhaustive means with which Ireland Army Hospital and the MEDDAC may manage all of its resources, i.e., personnel, funds, equipment, supplies, space, energy and time.

Optimum Feasible Quality Assurance Program Committee Structure

QAPC Alternative Five is the optimum feasible committee structure for the QAPC's within Ireland Army Hospital. Appendix K depicts the QAPC optimum feasible solution.

Through QAPC Alternative Five the existing Medical Care Evaluation Committee (MCEC) would become the hospital's Quality Assurance Program Committee. This new committee would discharge the functions of the former MCEC as it assumes the larger mission of receiving, evaluating, acting upon and coordinating the recommendations and the administration of the remaining QAPC's. Committees excluded from the Quality Assurance Program Committee's jurisdiction would be the Executive Committee, the Credentials Committee, the Hospital Accreditation Committee and the Medical Library Committee.

The three criteria for committee structure are achieved by the proposed QAPC structure. QAPC membership cost is maximized by consolidation of committees, committee functions and schedules. Built-in QAPC integrative reporting mechanisms significantly enhance the coordination between the QAPC's.

This optimal integration of effort allows the QAPC to exceed the requirements of the AMEDD and the standards of JCAH. The proposed QAPC structure achieves what the JCAH would classify as a comprehensive, integrated Quality Assurance Program. A written Quality Assurance Plan may be achieved by the appropriate revision of MEDDAC Regulation 15-1, incorporating all of the features of QAPC Alternative Five with the appropriate specifics described in QAPC Alternatives Two, Three and Four. The JCAH requirement for an organization chart of Ireland Army Hospital's QAP is satisfied by the Optimum Feasible QAPC Structure at Appendix K.

Recommendations

The following recommendations are submitted in order to augment the implementation of the two optimum feasible solutions to the Resources Management and Quality Assurance Program Committee structures and enhance the committee structure of Ireland Army Hospital.

1. RMC and QAPC chairpersons and key administrative and clinical staff members should be afforded the opportunity to review this study, its conclusions and recommendations in an attempt to incorporate their expertise into what will evolve as a complete renovation of Ireland Army Hospital's committee structure. By allowing the staff to participate in the re-design of the RMC and QAPC structures they will have a greater interest in and commitment to the successful implementation of the changes.[1]

2. A comprehensive implementation plan should be devised for the phasing-in of the conclusions and recommendations of this study. Action responsibilities and target dates should be assigned with periodic monitoring by a steering mechanism, the most appropriate of which would be the Executive Committee.

3. Consideration should be given to assigning the responsibility for development of the implementation plan to the 1980-1981 Administrative Resident.

4. Within the implementation plan there should be developed a comprehensive command policy which would enable the Ireland Army Hospital and MEDDAC committees to be uniformly organized. This policy must codify the following matters within MEDDAC Regulation 15-1:

a. The format for the description of each committee and sub-committee should include the committee title, references, mission, primary and secondary committee functions, membership, methodology of membership and committee leadership selection, membership quorum, meeting frequency with specific guidance for month, week, day, time and location, and required integrative reporting procedures.

b. Membership selection procedures should be defined within the command policy.

c. The method of appointing committee members, committee chairpersons, alternate chairpersons, recorders and their alternates should be addressed in the command policy.

d. Committee membership orientations for newly-appointed members should be required by the command policy. The orientation should be in writing and should ideally include a personal interview with the committee chairperson or recorder. Every aspect of the committee and the new member's role within the committee should be included within the orientation.

e. The command policy should define the roles of the committee chairperson, recorder, and member. Appendix L represents a brief description of key committee leadership and membership roles.

f. The command policy should consider requiring that committee chairpersons, recorders and members document their committee participation and leadership objectives within their Officer Evaluation Report Support Form, DA Form 67-8-1. Committee members' and leaders' efficiency reports should reflect their contributions to the improved effectiveness of their assigned committees to include their participation and attendance.

g. An official position concerning committee attendance and representation by informed, prepared alternate members should be defined within the command policy.

h. The command policy should require each committee to establish a quorum rule. An example of an acceptable quorum rule should be given.

i. Responsibilities of the committee chairperson and recorder for the proper preparation for each committee meeting should be included in the command policy. Appendix M represents a program evaluation review technique, PERT, chart which depicts an example of the steps required for optimal preparation for a committee meeting.

j. The command policy should specify the purpose, format, suspense requirements, reporting and filing procedures for committee minutes. Appendix N represents a proposed format for completed committee minutes.

k. The requirement, purpose, suspense requirements and format for committee meeting agendas should be addressed in the command policy. Appendix O represents a proposed agenda format for committee meetings.

l. The command policy should address the committee requirements of subordinate commands such as Hawley Army Health Clinic at Fort Benjamin-Harrison, Indiana. The titles, missions and reporting procedures for Hawley Army Health Clinic should be defined.

5. Within the implementation plan each chairperson should be tasked to conduct with the committee's assistance an extensive review of the committee in an overall systems context. Each committee review should closely examine all of the committee's applicable references, the committee's functions, membership and methodology for selection, and the committee's managerial policies and procedures. A target date should be established for the committee's review

completion and the submission of appropriate changes to MEDDAC Regulation 15-1.

6. A brief training session for committee chairpersons and recorders should be a component within the comprehensive implementation plan. The objective of the training session would be to emphasize the importance of the leadership roles within the committee management and administration. Ideally, the training session would be scheduled on a semi-annual basis. Appendix P represents a proposed outline of a chairperson and recorder training program.

7. Considerations which should be addressed within the implementation plan for the scheduling of meetings follow:

a. Patient appointments should be blocked-out for physicians and other health care providers when committee meetings are routinely held on appointed months, weeks, dates, and hours. Such scheduling consistancy would not only improve committee meeting attendance, but would prevent health care providers from departing meetings early and would prevent patients from waiting needlessly.

b. Large committee meetings should be scheduled in order to coincide with regularly scheduled general information meetings such as the Commander's Combined Staff Conference, the Executive Officer's Administrative Staff Meeting and the Chief of Professional Services' Chiefs' Meeting. Schedule consolidation such as this would not only

improve attendance, but would save on committee members' transition time.

c. Promotion and award ceremonies should be scheduled in large conference rooms inbetween large committee meetings. This would improve the ceremonies' attendance as well as conserve the staff's transition time.

d. Additional study is warranted concerning the scheduling of "marathon" meeting days. As revealed in the staff's responses to the Ireland Army Hospital Committee Questionnaire, this mechanism of committee meeting schedule consolidation was satisfactorily received by both the administrative and the clinical staff.

e. Consideration should be given to the possibility of initiating meetings by telephone conference calls. Such a mechanism in lieu of an actual, physical meeting could save considerable staff transition time. A trial period would be appropriate. This consideration should probably only apply to small committee meetings.

8. Within the realm of the Quality Assurance Program Committee structure there are three issues which deserve emphasis:

a. Whenever feasible, membership on and leadership of QAPC's should be entrusted to those capable individuals who have expressed an interest in or a preference for participation in quality assessment and assurance within the QAPC structure.

b. The discussion of QAPC cost factors, reporting mechanisms, and satisfaction of standards should not detract from the primary purpose of the Quality Assurance Program Committees: that of improving the quality of patient care delivered at Ireland Army Hospital. Neither perfect committee documentation, nor the mountains of accompanying paperwork are worthwhile, if patient care is not enhanced.[2]

c. There should exist a closed loop between the patient care evaluation studies of QAPC's and the departmental and hospital continuing medical education programs. A second goal of the QAPC should be the alteration of health care provider behavior through pertinent and timely continuing medical education. Refer to Figure 1 on page 18.[3]

FOOTNOTES

[1]Em Bevis, M.A., R.N., Dean, School of Nursing, University of Southern Georgia, Lecture to the Fort Knox, KY, Ireland Army Hospital Department of Nursing Workshop, "The Dynamics of Motivating Change," 29 March 1980.

[2]Richard E. Thompson, M.D., Quality Assurance Consultant, Lecture to Kentucky Peer Review Organization participants, "Audit/MCE Update; A New Perspective in Quality Assurance," 6 September 1979.

[3]Allan R. Threet, "A Study to Determine the Optimum Feasible Plan for a Comprehensive Quality Assurance Program Integrated with a Continuing Medical Education Program at Santa Rosa Medical Center, San Antonio, TX," a Health Care Systems Research Paper for the Graduate Health Care Administration Program, U.S. Army-Baylor University, Academy of Health Sciences, Fort Sam Houston, TX, 29 June 1979.

APPENDIX A

GLOSSARY

GLOSSARY

Committee - A group of two or more people to whom has been delegated a defined, continuing mission which it collectively investigates, evaluates, and monitors. A committee is primarily concerned with problem-solving and decision-making.

Meeting - The gathering together of two or more people for the purpose of sharing and/or collecting information.

Sub-committee - A group of two or more people who, as members of a larger group, are assigned the responsibility for accomplishing a defined mission which is a function of the larger group. A sub-committee's mission may be either continuing or limited to a specific objective or time frame.

Task Group, Task Force or Ad Hoc Committee - A group of people to whom has been delegated on a temporary basis a specific, limited objective of a nonrecurrent nature. Once the assignment of a task force/group or ad hoc committee has been accomplished the group will be relieved of their responsibility and disbanded.

APPENDIX B

COMMITTEE MEMBERSHIP

COST CHARTS

COMMITTEE MEMBERSHIP COST CHART

(Military)

The following chart depicts the average hourly salary for military committee members for use in estimation of the personnel costs of convening committee meetings. The chart does not reflect physician and other officer incentive bonuses. The chart simply reflects basic pay without quarters and subsistence allowances. Base pay figures have been rounded to the nearest $100.00 and are the result of arbitrarily selected years in service for each pay grade. Hourly salaries are figured on the nearest half-dollar. The source for the chart is the military pay chart dated 1 October 1979.

RANK/GRADE	HOURLY SALARY	ANNUAL SALARY	YEARS IN SERVICE
COL 0-6	$15.50	$29,400.00	16
LTC 0-5	$13.00	$24,600.00	14
MAJ 0-4	$12.00	$22,200.00	12
CPT 0-3	$10.00	$19,200.00	8
1LT 0-2	$ 8.00	$15,600.00	3
2LT 0-1	$ 5.00	$10,200.00	Under 2
CW2 CW2	$ 7.50	$14,400.00	12
SGM E-9	$ 8.50	$16,200.00	16
MSG E-8	$ 7.00	$13,800.00	14
SFC E-7	$ 6.50	$12,000.00	12
SSG E-6	$ 5.50	$10,200.00	10
SGT E-5	$ 5.00	$ 9,000.00	8
SP4 E-4	$ 4.50	$ 8,400.00	6
PFC E-3	$ 3.80	$ 7,200.00	4
PVT E-2	$ 3.00	$ 6,000.00	Under 2
PV1 E-1	$ 3.00	$ 5,400.00	Under 2

COMMITTEE MEMBERSHIP COST CHART

(Civilian Employee)

The following chart depicts the average hourly salary for civil service committee members for use in estimation of the personnel costs of convening committee meetings. The chart does not reflect rates established under 5 U.S.C. 5303 for recruitment/retention of special skills such as are paid to physicians. Annual base pay figures have been quantitatively manipulated so as to reflect hourly salaries on the basis of 160 duty hours per month. Step 5 has been arbitrarily utilized for each GS pay grade. The hourly rates have been rounded to the nearest half-dollar. The source for the chart is the civil service pay chart effective 7 October 1979.

GRADE	HOURLY SALARY	ANNUAL SALARY
GS-15	$24.00	$46,276.00
GS-14	$20.50	$39,341.00
GS-13	$17.50	$33,291.00
GS-12	$15.00	$27,995.00
GS-11	$12.00	$23,359.00
GS-10	$11.00	$21,260.00
GS-9	$10.00	$19,307.00
GS-8	$ 9.00	$17,479.00
GS-7	$ 8.00	$15,781.00
GS-6	$ 7.50	$14,203.00
GS-5	$ 7.00	$12,743.00
GS-4	$ 6.00	$11,389.00
GS-3	$ 5.50	$10,144.00
GS-2	$ 5.00	$ 9,002.00
GS-1	$ 4.00	$ 8,170.00

APPENDIX .C

RESOURCES MANAGEMENT

COMMITTEES

RESOURCES MANAGEMENT

COMMITTEES

Review and Analysis (R&A)

Program Budget Advisory Committee (PBAC)

Automation Guidance Council (AGC)

MEDDAC Engineer Review Board (MERB)

Energy Conservation Task Group (ECTG)

Position Management Review Team (PMRT)

Civilian Training Committee (CTC)

Military Awards Committee (MAC)

COMMITTEE ANALYSIS SHEET

1. Committee Title and Meeting Frequency:

   a. Review and Analysis (R&A);

   b. Monthly.

2. Committee References:

   a. AR 5-2;

   b. AR 5-3;

   c. AR 5-4;

   d. AR 10-5;

   e. AR 11-18;

   f. AR 37-15;

   g. AR 37-100 and AR 37-100-FY with HSC Supplements;

   h. DA Pamphlet 5-10;

   i. DA Pamphlet 37-4;

   j. DA Pamphlet 325-10;

   k. HSC Regulation 11-series;

   l. HSC Operating Program;

   m. MEDDAC Regulation 11-2;

3. Committee Cost Factor:

   a. Average cost per meeting: $172.00;

   b. Average cost per year: $2,064.00.

   c. Notes:

(1) The Director of the Blood Bank Center and other regular attendees not listed as members in MEDDAC Regulation 15-1 are not included in the staff cost factor.

(2) It is assumed that twelve R&A's will be held each year.

(3) The meeting duration is calculated to be one hour on the basis of this analyst's observations.

4. Committee Integration/Coordination:

a. Receipt of input/feedback:

(1) The major participants of the R&A, i.e., the Comptroller, Chief, Logistics Division, and Chief, Personnel Division, utilize the most currently available data.

(2) The R&A does not now receive or consider the minutes of the PBAC, MERB or any other RMC in the conduct of its business.

b. Distribution of output/feedback: The R&A does not currently prepare minutes for documentation of its business.

5. Committee Satisfaction of AMEDD/JCAH Requirements/Standards:

a. AMEDD requirements:

(1) Satisfactory.

(2) The committee Appendix fails to define what represents a quorum IAW HSC Pamphlet 40-1, paragraph 1-1a.

b. JCAH standards: JCAH AMH Standard VI under Governing Body is applicable and is being satisfied with the exception of the lack of documentation of the R&A's meetings.

6. Committee Management/Administration Analysis:

a. Reporting mechanisms: There are currently no R&A reporting mechanisms. Minutes are not routed to the Executive Committee, PBAC, MERB nor any other RMC for information/ coordination.

b. Committee meetings:

(1) The agenda and format for the R&A is excellent.

(2) Advanced notification for R&A's is excellent.

(3) The MEDDAC Regulation 15-1 Appendix 24 meeting information is specific to week, date and time. The location is not indicated.

c. Committee membership: Appropriate. Alternate members are not authorized, appointed, nor required.

d. Committee functions:

(1) Appendix 24 makes reference to MEDDAC Regulation 11-2 for the R&A's functions. The R&A responsibilities are not listed nor are they briefly defined in MEDDAC Regulation 15-1.

(2) The assignment of responsibility for Recorder duties to the Administrative Resident is inappropriate. Recorder responsibilities are not assigned on a functional basis.

COMMITTEE ANALYSIS SHEET

1. Committee Title and Meeting Frequency:

    a. Program Budget Advisory Committee (PBAC);

    b. Quarterly and at the call of the chairperson.

2. Committee References:

    a. AR 37-100;

    b. HSC Regulation 11-1;

    c. DA Pamphlet 35-10;

    d. HSC Pamphlet 40-1;

    e. JCAH AMH Governing Body Standard VI.

3. Committee Cost Factor:

    a. Average cost per meeting: $193.50;

    b. Average Cost per year: $774.00.

    c. Notes:

    (1) It is calculated that the PBAC will meet four times per year.

    (2) The duration of the PBAC is estimated to be one hour per review of the minutes and this analyst's observations.

    (3) DENTAC, Veterinary Activity, Hawley Army Health Clinic, and The Blood Bank Center members are not included in the cost factor.

4. Committee Integration/Coordination:

    a. Receipt of input/feedback:

    (1) The PBAC currently receives information from its key members.

    (2) The PBAC currently receives no direct, written input from the R&A, the MERB or other RMC's.

    b. Distribution of output/feedback:

    (1) The PBAC currently reports the results of its meetings directly to the Commander.

(2) MEDDAC Regulation 15-1 does not specify that the PBAC minutes should be reviewed by the Executive Committee.

5. Committee Satisfaction of AMEDD/JCAH Requirements/Standards:

a. AMEDD requirements:

(1) Satisfactorily met with improvement options available.

(2) The committee Appendix fails to define what represents a quorum IAW HSC Pamphlet 40-1, paragraph 1-1a.

b. JCAH standards: The JCAH AMH Governing Body Standard VI is applicable and is generally being met. Improvement is possible.

6. Committee Management/Administration Analysis:

a. Reporting mechanisms:

(1) According to MEDDAC Regulation 15-1 the PBAC does not report its minutes to the Executive Committee in order to enhance the coordination and integration of that body.

(2) The PBAC does not receive the minutes of the R&A, the Automation Guidance Council, the PMRT and the MERB in order to enhance its own coordination/integration with other hospital committees.

b. Committee meetings:

(1) The agenda and format for the PBAC is excellent.

(2) Advanced notification for the PBAC is excellent.

(3) MEDDAC Regulation 15-1 Appendix 8 is not explicit about the month, week of month, day of week, time and location of its quarterly meetings.

c. Committee membership: The Chief, Plans, Operations and Training Division is not listed as a PBAC member, when required for matters involving that division.

d. Committee functions:

(1) Paragraph 5a(7) of Appendix 8 assigns responsibility for space utilization to the PBAC. This function has historically received minimal emphasis by the PBAC. This is particularly crucial in view of the hospital's ongoing renovation project.

(2) It is inappropriate that MEDDAC Regulation 15-1 includes specific guidance on how to requisition equipment under the PBAC MEDCASE Program as is the case at page B-8-A-1 through -3. MEDDAC Regulation 15-1 is required by HSC Pamphlet 40-1 to define a committee's purpose, authority, responsibilities and functions, not necessarily the specific associated procedures. Equipment requisitioning procedures would more appropriately be addressed in another MEDDAC regulation.

7. PBAC Sub-Committees. The PBAC has two sub-committees, the Program Budget Advisory Executive Committee (PBAEC) and the Working Program Budget Advisory Committee (WPBAC). The following observations are made about those committees:

a. PBAEC.

(1) Cost per meeting: $105.50.

(2) Reporting mechanism: It is uncertain from Appendix 8 of MEDDAC Regulation 15-1 whether or not the PBAEC's minutes are distributed to and reviewed by the PBAC.

(3) Committee membership: Appropriate.

(4) Functions are appropriate, providing the PBAEC reports its actions to the PBAC and to the Commander through the Executive Committee.

b. WPBAC.

(1) Cost per meeting: $85.00.

(2) Reporting mechanism: The WPBAC is a sub-committee designed to insure preparations for the PBAC meeting. Reporting mechanisms are, therefore, unnecessary.

(3) Committee membership: Appropriate.

(4) Committee functions: Appropriate. Functions are essential for the planning, preparations and operation of an effective PBAC.

COMMITTEE ANALYSIS SHEET

1. Committee Title and Meeting Frequency:

   a. Automation Guidance Council (AGC);

   b. At the call of the chairperson.

2. Committee References:

   a. AR 18-1, Policies, Objectives, Procedures, and Responsibilities, 22 March 1976, and HSC Supplement 1, 29 August 1977, thereto;

   b. AR 18-7, Data Processing Activity Management, Procedures and Standards, 15 May 1978;

   c. DOD Directive 6000-5, Tri-Service Medical Information System (TRIMIS) program, June 1976;

   d. HQDA Letter 40-79-2, 2 February 1979, subject: Medical Automatic Data Processing Systems and Equipment Approval Authorities;

   e. HSC Memo No. 15-14, dated 3 November 1979, Automation Guidance Council.

3. Committee Cost Factor:

   a. Average cost per meeting: $123.50;

   b. Average Annual Cost: $247.00.

   c. Notes: The AGC is a recently established function which has not yet met. The average annual cost is calculated for two meetings per year.

4. Committee Integration/Coordination:

   a. Receipt of input/feedback: IAW MEDDAC Regulation 15-1, the AGC does not review minutes of the PBAC and R&A committees in order to assist in its long-range planning roles.

   b. Distribution of output/feedback: The AGC does not route its minutes through the PBAC to the Executive Committee.

5. Committee Satisfaction of AMEDD/JCAH Requirements/Standards:

a. AMEDD requirements:

(1) Due to the fact that this committee has not yet met, AMEDD requirements have not yet been accomplished.

(2) The committee Appendix fails to define what represents a quorum IAW HSC Pamphlet 40-1, paragraph 1-1a.

b. JCAH standards: The AGC's mission is an institutional planning mission similar to that of the PBAC and MERB. JCAH AMH Governing Body Standard VI is applicable.

6. Committee Management/Administration Analysis:

a. Reporting mechanisms: The AGC does not route its committee minutes through the PBAC to the Executive Committee.

b. Committee meetings: Periodic, scheduled, meetings are not established by quarter, month, week of month, day of week, time of day and location.

c. Committee membership:

(1) The Health Facility Project Officer is not a member of the AGC.

(2) Paragraph 3 of the AGC Appendix is excellent whereby AGC members are authorized to appoint alternate members.

d. Other: Paragraph 2c of the AGC Appendix 22 allows one week for submission of minutes. The MEDDAC policy is ten duty days.

COMMITTEE ANALYSIS SHEET

1. Committee Title and Meeting Frequency:

   a. MEDDAC Engineer Review Board (MERB);

   b. Monthly and at the call of the chairperson.

2. Committee References:

   a. There is one reference listed: CG HSC Bulletin 11-74, paragraphs 8a and b;

   b. JCAH AMH Governing Body Standard VI is applicable.

3. Committee Cost Factor:

   a. Average cost per meeting: $89.00;

   b. Average cost per year: $1068.00;

   c. Notes:

      (1) Each meeting is estimated to be one hour long as per review of the minutes and this analyst's observation of the meetings.

      (2) The cost figures do not include DFAE, Veterinary Activity and DENTAC member costs.

      (3) The per year cost assumes twelve monthly meetings.

4. Committee Integration/Coordination:

   a. Receipt of input/feedback:

      (1) Agenda input from members is satisfactory.

      (2) The MERB does not review the PBAC and R&A committee minutes as it makes its long-range and short-range plans for the MEDDAC.

   b. Distribution of output/feedback:

      (1) The committee minutes are distributed on a timely basis.

      (2) The committee does not route its minutes through the PBAC and R&A committees to the Executive Committee for maximum coordination and integration of effort.

5. Committee Satisfaction of AMEDD/JCAH Requirements/Standards:

a. AMEDD requirements:

(1) Generally accomplished.

(2) The committee Appendix fails to define what represents a quorum IAW HSC Pamphlet 40-1, paragraph 1-1a.

b. JCAH standards: The MERB is an expansion of the PBAC as it complies with the JCAH requirement for institutional planning. In this regard, JCAH standards are met.

6. Committee Management/Administration Analysis:

a. Reporting mechanisms: Excellent.

b. Committee meetings:

(1) Frequency: appropriate.

(2) Specific guidance on day of week, week of month, time of day and location is excellent.

c. Committee membership:

(1) Four staff members from Logistics Division are not required on the committee. The Chief, Logistics Division need not be on the committee since the Chief, Service Branch may serve as a representative. The Chief, Medical Maintenance and NCOIC, Utilities Branch are not listed as consultants, who attend on an as needed basis.

(2) The Deputy, Veterinary Activity and Executive Officer, DENTAC are not considered as members only when committee business pertains to their activity.

(3) The Health Facility Project Officer is not a consulting member.

(4) MEDDAC Regulation 15-1 does not indicate that the Chief, Work Reception and Scheduling Branch is a representative from DFAE.

(5) A representative for the Chief, Professional Services is not specifically authorized.

(6) The Chief, Clinical Support Division or a representative is not a member of the committee.

COMMITTEE ANALYSIS SHEET

1. Committee Title and Meeting Frequency:

   a. Energy Conservation Task Group (ECTG);

   b. Quarterly and at the call of the chairperson.

2. Committee References:

   a. HSC Regulation 11-3 is listed in the MEDDAC Regulation 15-1;

   b. The appropriate USAARMC references are not listed.

3. Committee Cost Factor:

   a. Average cost per meeting: $53.00;

   b. Average cost per year: $212.00.

   c. Notes:

   (1) The Director, The Blood Bank Center and Executive Officer, DENTAC are not included in the cost factor.

   (2) Each meeting is estimated to be one hour long as per review of the minutes and this analyst's observation of the meetings.

   (3) The average cost per year assumes four quarterly meetings.

4. Committee Integration/Coordination:

   a. Receipt of input/feedback:

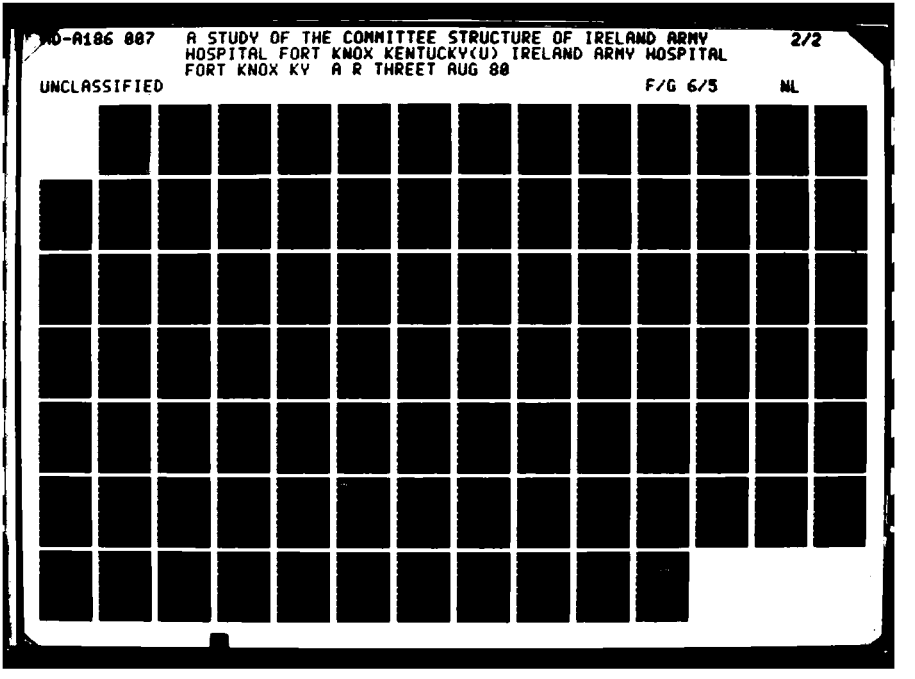
   (1) Agenda input: Satisfactory;

   (2) The committee does not receive and review the minutes of the MERB as additional input for energy [illegible] considerations.

   b. Distribution of output/feedback:

   (1) The committee minutes are distributed on a timely basis.

   (2) The committee does not [illegible] the MERB and the PBAC to the Executive [illegible]


AD-A186 007 A STUDY OF THE COMMITTEE STRUCTURE OF IRELAND ARMY HOSPITAL FORT KNOX KENTUCKY(U) IRELAND ARMY HOSPITAL FORT KNOX KY A R THREET AUG 88
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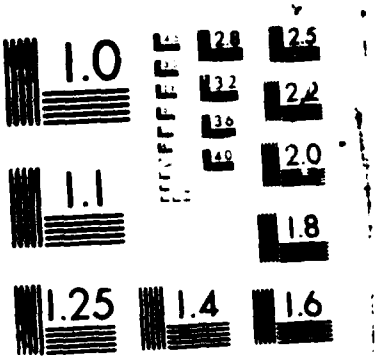


5. Committee Satisfaction of AMEDD/JCAH Requirements/Standards:

a. AMEDD requirements:

(1) Satisfactory.

(2) The committee Appendix fails to define what represents a quorum IAW HSC Pamphlet 40-1, paragraph 1-1a.

b. JCAH Requirements: Non-applicable.

6. Committee Management/Administration Analysis:

a. Reporting mechanisms: The committee's minutes are not routed through the MERB and the PBAC to the Executive Committee.

b. Committee meetings:

(1) Frequency: Appropriate.

(2) Specific guidance is excellent where the MEDDAC Regulation 15-1 lists the day of week, week of month, time of day and the location.

c. Committee membership:

(1) The DFAE Hospital Engineer is not listed as a member in MEDDAC Regulation 15-1. The committee's 5 May 1980 meeting approved this membership addition.

(2) Both the Chief, Logistics Division and the Chief, Service Branch do not need to serve on the committee.

(3) The committee membership listing does not authorize a representative for the members.

(4) The Health Facility Project Officer is not a committee member.

(5) The committee's name is inappropriate. See Appendix A for the definition of a Task Group.

COMMITTEE ANALYSIS SHEET

1. Committee Title and Meeting Frequency:

    a. Position Management Review Team (PMRT);

    b. Weekly or at the call of the chairperson.

2. Committee Reference:

    HSC Regulation 690-2.

3. Committee Cost Factor:

    a. Average cost per meeting: $43.00;

    b. Average cost per month: $172.00;

    c. Average cost per year: $2236.00.

    d. Notes:

    (1) It is assumed that the team meets weekly as per MEDDAC Regulation 15-1.

    (2) It is assumed that the meeting lasts for one hour.

4. Committee Integration/Coordination:

    a. Receipt of input/feedback: The PMRT does not review the minutes of the R&A and PBAC in order to maximize its mission accomplishment.

    b. Distribution of output/feedback: The PMRT does not route its minutes through the Executive Officer to the PBAC and the Executive Committee.

5. Committee Satisfaction of AMEDD/JCAH Requirements/Standards:

    a. AMEDD requirements:

        (1) Generally accomplished.

        (2) The committee Appendix fails to define what represents a quorum IAW HSC Pamphlet 40-1, paragraph 1-1a.

    b. JCAH standards: Non-applicable.

6. Committee Management/Administration Analysis:

a. Reporting mechanisms: MEDDAC Regulation 15-1 states that PMRT's minutes will go to the Position Management Officer who is the Hospital Executive Officer. The regulation does not indicate that the XO's review is routed to the PBAC and the Executive Committee.

b. Committee meetings:

(1) Frequency: While MEDDAC Regulation 15-1 states that the PMRT meets weekly, actual minutes available indicate much less frequency of meetings and/or documentation thereof.

(2) Specific guidance as to the time of day, day of week, month and location is lacking.

c. Committee membership: Appropriate.

d. Committee functions: Appropriate.

COMMITTEE ANALYSIS SHEET

1. Committee Title and Meeting Frequency:

   a. Civilian Training Committee (CTC);

   b. Quarterly.

2. Committee References:

   a. FPM Chapter 410, Training;

   b. CPR 700, Appendix F, Guidelines for UMP;

   c. HSC Regulation 690-1, Central Training Fund Program;

   d. HSC Regulation 690-3, Civilian Training & Development;

   e. MEDDAC Memorandum 630-6, Temporary Duty TDY Assignments;

   f. CPP #46, Role of the Training Committee.

3. Committee Cost Factor:

   a. Average cost per meeting: $96.00;

   b. Average cost per year: $384.00.

   c. Notes:

   (1) The duration of each meeting is calculated to be one hour.

   (2) It is assumed that the committee meets once per quarter as per MEDDAC Regulation 15-1.

   (3) The cost factors do not include staff members from Community Mental Health Activity, The Blood Bank Center, Post Civilian Personnel Office, Federal Women's Program Coordinator and the union.

4. Committee Integration/Coordination:

   a. Receipt of input/feedback: Satisfactory.

   b. Distribution of output/feedback: The committee does not report through the Executive Officer to the Executive Committee. The committee reports directly to the Commander. Since the mission of the committee is to plan, coordinate and

evaluate civilian employee's training and development it is a key concern to the Executive Committee that its mission is accomplished effectively.

5. Committee Satisfaction of AMEDD/JCAH Requirements/Standards:

a. AMEDD requirements:

(1) Generally accomplished.

(2) The committee Appendix fails to define what represents a quorum IAW HSC Pamphlet 40-1, paragraph 1-1a.

b. JCAH standards: Appropriate.

6. Committee Management/Administration Analysis:

a. Reporting mechanisms: See paragraph 4b above.

b. Committee meetings: Specific guidance is lacking in MEDDAC Regulation 15-1 regarding the month, week of month, day of week, time of day and location of the quarterly meetings.

c. Committee membership:

(1) The committee's Appendix 13 in MEDDAC Regulation 15-1 does not specify that alternate members are acceptable in the absence of those appointed.

(2) A representative for the Chief, Professional Services is not listed in the committee's membership. This is essential in view of the civilian physicians on the staff.

d. Committee functions: It is inappropriate that a committee which meets only quarterly should include within its functions the responsibility to prepare an annual report as per paragraph 3d. The Chief, Personnel Division should prepare the report and the committee should review it.

e. Other: The committee allows itself 5 duty days to complete its minutes. The MEDDAC policy is ten duty days.

COMMITTEE ANALYSIS SHEET

1. Committee Title and Meeting Frequency:

   a. Military Awards Committee (MAC);

   b. Quarterly and at the call of the chairperson.

2. Committee References:

   AR 672-5-1 with HSC Supplement.

3. Committee Cost Factor:

   a. Average cost per meeting: $82.00;

   b. Average cost per year: $1312.00.

   c. Notes:

   (1) Each meeting is estimated to be one hour in duration.

   (2) The annual average cost assumes four quarterly meetings.

4. Committee Integration/Coordination:

   a. Receipt of input/feedback: Satisfactory.

   b. Distribution of output/feedback: Appropriate.

5. Committee Satisfaction of AMEDD/JCAH Requirements/Standards:

   a. AMEDD requirements:

   (1) Generally accomplished.

   (2) The committee Appendix fails to define what represents a quorum IAW HSC Pamphlet 40-1, paragraph 1-1a.

   b. JCAH standards: Non-acceptable.

6. Committee Management/Administration Analysis:

   a. Reporting mechanisms: Appropriate.

   b. Committee meetings: Specific guidance is lacking in the MEDDAC Regulation 15-1 which would indicate the month, week of month, day of week, time of day and location of the quarterly meetings.

c. Committee membership:

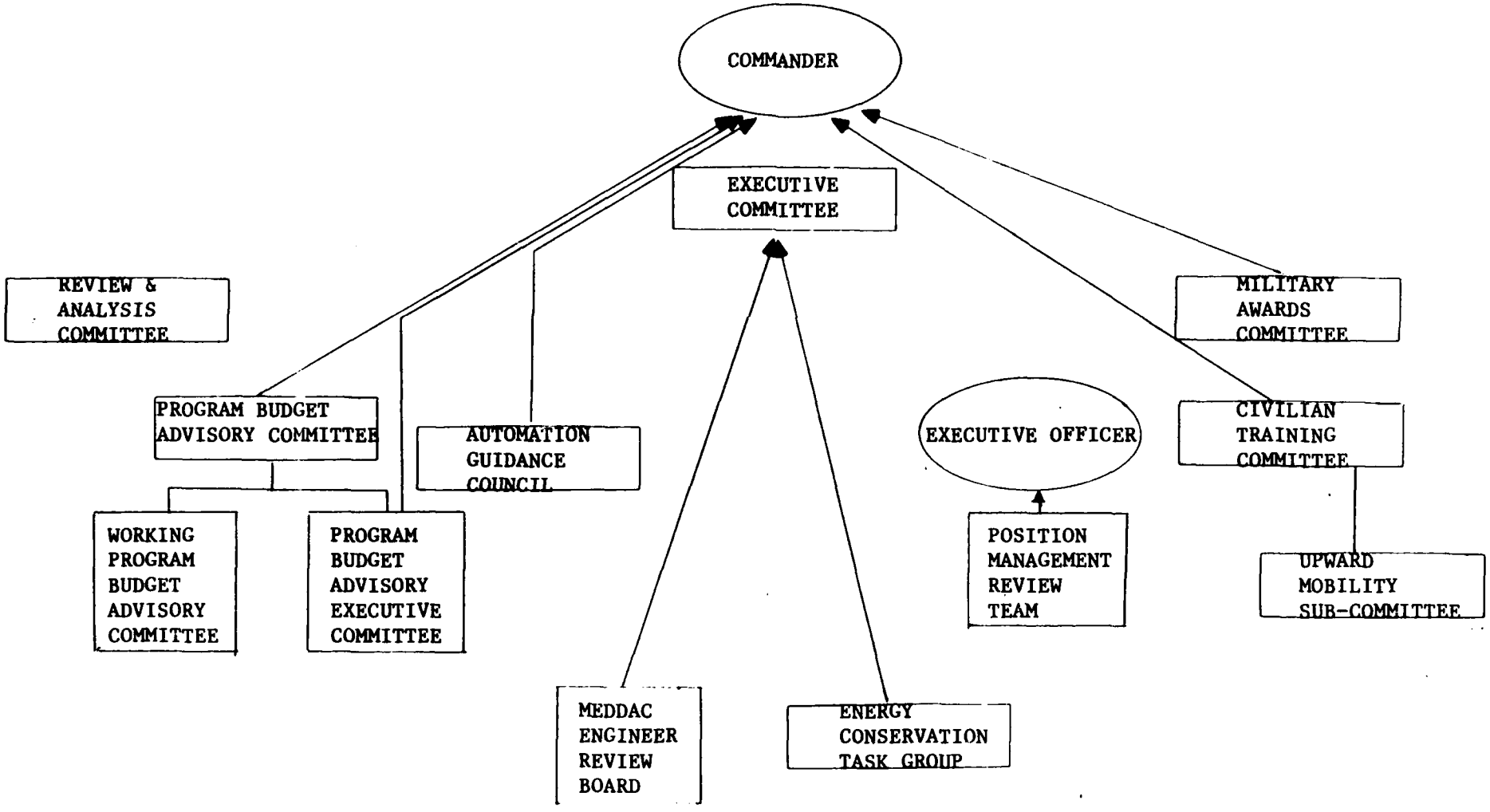
(1) The committee does not include representatives of MEDDAC activities in addition to Ireland Army Hospital staff members. Activities excluded include Preventive Medicine Activity, Community Mental Health Activity, Veterinary Activity, and The Blood Bank Center. The committee now is weighted to favor Ireland Army Hospital staff members.

(2) It is inappropriate that MEDDAC Regulation 15-1 includes specific guidance on how to submit a military award as per Appendix 23, Annex B, paragraph 3a and Annex A, page B-23-3. MEDDAC Regulation 15-1 is required by HSC Pamphlet 40-1 to define a committee's purpose, authority, responsibilities and functions, not necessarily the specific associated procedures. It is more appropriate that instructions on submission of military awards be addressed in another source such as another MEDDAC regulation.

APPENDIX D

CURRENT RESOURCES MANAGEMENT COMMITTEE STRUCTURE

CURRENT RESOURCES
MANAGEMENT COMMITTEE
STRUCTURE



(Source: MEDDAC Regulation 15-1, "Boards, Councils and Committees," with Change 1, 5 February 1980.)

APPENDIX E

QUALITY ASSURANCE PROGRAM

COMMITTEES

CURRENT
RESOURCES MANAGEMENT
COMMITTEE STRUCTURE
MEMBERSHIP MATRIX

COMMITTEE MEMBERS	COMMITTEES							
	R&A	PBAC	AGC	MLRB	ECTG	PMRT	CTC	MAC
CDR	XXX							
XO	X	XXX	XXX	XXX	XXX			XXX
C,PS	X	X	X	X				X
C,DoN	X	X	X		X			X
C,PAD	X		X				X	
C, PERS	X	X	X			XXX	XXX	XX
C, FD SVC	X	(X)					X	
C, COMPT	X	X	XX			X		
C, LOG	X	X	X	X	X			
C, FORCE DEV		X				X		
HFPO		(X)						
C, SVC BR				X/(XX)	XX			
C, MED MAINT		(X)		X				
CSM								X
1SG								X
C, WARD MASTER								X
C,CSD	X	X	X		X			
C, PHARM	X							
LAB OFFICER	X							
ADMIN RES	XX							
C,D MED		X						
C,D SURG		X						
C, PO&T		X	X					
C, PROJ & BUDGET		(XX)						
ADJUTANT			X					
NCOIC, UTILITIES				X				
PERS SVCS ASST						XX	XX	
C, NETS							X	
MEETING FREQUENCY	M	Q	At Call	M	Q	W	Q	Q

CODES:

XXX = Committee Chairperson
XX = Committee Recorder
X = Committee Member
(XX) = Representative is Committee Recorder or Recorder without vote
(X) = Committee Member as needed or without vote

M = Monthly
Q = Quarterly
W = Weekly

QUALITY ASSURANCE PROGRAM

COMMITTEES

Executive Committee (EC)

Credentials Committee (CC)

Hospital Accreditation Committee (HAC)

Medical Care Evaluation Committee (MCEC)

Medical Record Audit Committee (MRAC)

Therapeutic Agents Board (TAB)

Tumor Board (TB)

Infection Control Committee (ICC)

Safety and Health Committee (S&HC)

Radiation Control Committee (RCC)

Ambulatory Patient Care Committee (APCC)

Emergency Medical Care Services Committee (EMCSC)

Utilization Review Committee (URC)

Rabies Advisory Board (RAB)

Medical Library Committee (MLC)

COMMITTEE ANALYSIS SHEET

1. Committee Title and Meeting Frequency:

   a. Executive Committee (EC);

   b. Daily.

2. Committee References:

   a. AR 40-400;

   b. AR 40-2;

   c. HSC Pamphlet 20-1;

   d. HSC Pamphlet 40-1;

   e. JCAH AMH.

3. Committee Cost Factor:

   a. Average daily cost: $80.50;

   b. Average monthly cost: $1610.00;

   c. Average annual cost: $19,320.00.

   d. Note: These figures assume one hour meetings with all members present for twenty duty days per month.

4. Committee Integration/Coordination:

   a. Receipt of input/feedback:

   (1) The Executive Committee currently reviews the minutes of every Ireland Army Hospital and MEDDAC committee despite what is required in MEDDAC Regulation 15-1.

   (2) The Executive Committee also reviews the Credentials Committee. This is in contravention to regulations which state that the Credentials Committee is to be reviewed by the Commander. See AR 40-400, paragraph 10-6c(1), HSC Pamphlet 40-1, paragraph 2-6g, and HSC Pamphlet 20-1, Medical Staff Standard II, page 64.

   (3) The Executive Committee currently reviews committee minutes twice per month. Committee minutes received inbetween scheduled reviews are held until the next review. This procedure inhibits committee actions. The TAB is offered as a prime example. TAB recommendations to the Commander through the Executive Committee require at least ten days for minutes

to be finalized and presented to the Commander's secretary for the next Executive Committee review. This may require an additional week to ten days. The Executive Committee's review, approval/disapproval and recommendations then require approximately three more days before which time the C, Pharmacy Service may initiate the appropriate medical supply requisitions. From the time the TAB makes its recommendation to add a medication to the formulary until the requisition is received by Logistics Division could conceivably be a month. Other committee actions are similarly effected.

b. Distribution of output/feedback:

(1) Minutes of each Executive Committee meeting are distributed to the concerned agencies on a daily basis.

(2) Executive Committee approval/disapproval and recommendations following review of committee minutes is documented solely in the Executive Committee minutes. While the Commander's secretary prepares a Disposition Form, DA Form 2496, which indorses the committee minutes with comments relative to attendance, approval/disapproval, further actions, etc., this DF is filed in the hospital headquarters and is not forwarded to the committee chairperson.

5. Committee Satisfaction of AMEDD/JCAH Requirements/Standards:

a. AMEDD requirements:

(1) The Ireland Army Hospital Executive Committee represents an information gathering and sharing meeting at which time problem-solving and decision-making occurs. The original purpose of the meeting is to receive the Department of Nursing's twenty-four hour report.

(2) The Executive Committee's review of the MEDDAC and Ireland Army Hospital committee minutes on a bi-monthly basis constitutes an official Executive Committee.

(3) While the current procedure of daily documentation by minutes is unnecessary according to AMEDD requirements, it serves as a valuable tool for distributing information throughout the hospital and MEDDAC and as a reminder to those individuals assigned action responsibilities.

(4) The committee Appendix fails to define what represents a quorum IAW HSC Pamphlet 40-1, paragraph 1-1a.

b. JCAH standards: The current Executive Committee exceeds the standards of the JCAH by its daily documentation and distribution of minutes.

6. Committee Management/Administration Analysis:

a. Reporting mechanisms:

(1) See paragraph 4a and b above.

(2) The Executive Committee lacks the capability to easily determine which committee minutes are due or past due for review.

(3) The Executive Committee lacks the capability to easily determine whether or not the committees are accomplishing their assigned functions in a timely, proper manner.

(4) As a result of 6a(2) and (3) above, the Executive Committee's review of the hospital's committee minutes is not optimally effective.

(5) MEDDAC Regulation 15-1 does not currently provide a checklist of functions for each committee. MEDDAC Regulation 15-1 does not require a specific format for each committee's minutes, nor for their agendas. Such control and follow-up would not only maximize the individual committee's effectiveness, but would also maximize the Executive Committee's effectiveness.

(6) The Executive Committee does not review incoming committee minutes on a timely basis. See paragraph 4a(3) above.

(7) The Executive Committee does not indorse incoming committee minutes back to the committee chairpersons on a timely basis and in an efficient, effective manner. See paragraph 4b(2) above.

b. Committee meetings: Appropriate and satisfactory.

c. Committee membership: Appropriate and satisfactory.

d. Committee functions:

(1) Appropriate and satisfactory.

(2) The Executive Committee's involvement in JCAH Survey preparations has contributed to the demise of the Hospital Accreditation Committee. A separate committee with additional input and insight could better discharge the function of JCAH coordination.

e. Other: The assignment of the Executive Committee recorder responsibility to the Administrative Resident is of mixed value. While greater skills have been developed by

the Administrative Resident in the concept of the organization of a MEDDAC and hospital, the time required to document the daily meetings has detracted somewhat from the residency.

COMMITTEE ANALYSIS SHEET

1. Committee Title and Meeting Frequency:

   a. Credentials Committee (CC);

   b. At the call of the chairperson.

2. Committee References:

   a. AR 40-400;

   b. HSC Pamphlet 20-1;

   c. HSC Pamphlet 40-1;

   d. JCAH AMH.

3. Committee Cost Factor:

   a. Average cost per meeting: $105.00;

   b. Average cost per year with four meetings: $420.00.

4. Committee Integration/Coordination:

   a. Receipt of input/feedback: Currently, the Credentials Committee does not receive input directly from the MCEC, the TAB, and the Medical Record Audit Committee. In order to fully comply with the spirit of the new JCAH QA standard such input to the Credentials Committee, when appropriate, would be beneficial.

   b. Distribution of output/feedback: The Credentials Committee currently reports its findings and recommendations to the Executive Committee. This is in contravention to HSC Pamphlet 40-1, paragraph 2-6g and HSC Pamphlet 20-1, JCAH Medical Staff Standard II, p. 64 and AR 40-400, paragraph 10-6c(1). The Credentials Committee Appendix 11 to MEDDAC Regulation 15-1 fails to specify a reporting mechanism for the committee.

5. Committee Satisfaction of AMEDD/JCAH Requirements/Standards:

   a. AMEDD requirements:

      (1) See paragraph 4b above.

      (2) The committee Appendix fails to define what represents a quorum IAW HSC Pamphlet 40-1, paragraph 1-1a.

   b. JCAH standards: Satisfactory.

6. Committee Management/Administration Analysis:

a. Reporting mechanisms: See paragraph 4b above.

b. Committee meetings: Satisfactory.

c. Committee membership: The Credentials Committee's Appendix 11 fails to specify ancillary consulting members as per HSC Pamphlet 40-1, paragraph 2-6a.

d. Committee functions: Appropriate.

e. Other:

(1) The committee's Appendix 11 fails to reference HSC Pamphlet 20-1, and HSC Pamphlet 40-1.

(2) The committee does not currently program its work so as to be able to meet at scheduled time intervals. Such action causes the meetings to be burdensome. Additional preparation for each committee meeting would lead to meetings of a briefer duration.

COMMITTEE ANALYSIS SHEET

1. Committee Title and Meeting Frequency:

   a. Hospital Accreditation Committee (HAC);

   b. At the call of the chairperson.

2. Committee References:

   a. JCAH AMH;

   b. AR 40-2;

   c. AR 40-400;

   d. HSC Pamphlet 40-1;

   e. HSC Pamphlet 20-1.

3. Committee Cost Factor:

   a. Average cost per meeting: $66.00;

   b. Average annual cost at six meetings per year: $396.00.

4. Committee Integration/Coordination:

   a. Receipt of input/feedback: Unsatisfactory. The HAC has not meet over the past twelve months.

   b. Distribution of output/feedback: See paragraph 4a above.

5. Committee Satisfaction of AMEDD/JCAH Requirements/Standards:

   a. AMEDD requirements:

      (1) AMEDD references do not require an HAC.

      (2) The committee Appendix fails to define what represents a quorum IAW HSC Pamphlet 40-1, paragraph 1-1a.

   b. JCAH standards: JCAH standards do not require an HAC.

6. Committee Management/Administration Analysis:

   a. Reporting mechanisms:

      (1) See paragraph 4a above.

(2) The HAC is not actively engaged in the JCAH accreditation status of the hospital. This involvement does not periodically encompass each standard in the JCAH AMH and the hospital's corresponding activities. In addition, the HAC is not involved in the preparation and monitoring of JCAH Survey Recommendations, JCAH Interim Self-Surveys and the JCAH Hospital Survey Profile.

(3) The HAC currently does not recommend to the Executive Committee that subordinate QAPC's be required to investigate, monitor and report on various JCAH accreditation issues.

b. Committee meetings: The committee does not meet on at least a bi-monthly basis and monthly beginning four months prior to a JCAH Survey.

c. Committee membership:

(1) The Chief, Department of Nursing is not a member of the committee.

(2) The Associate Administrator, a position which no longer exists, should be deleted from the committee membership.

(3) The Administrative Resident is not a member of the HAC.

(4) A committee recorder, other than the Associate Administrator and the Administrative Resident, has not been designated.

d. Committee functions: See paragraph 6a above.

COMMITTEE ANALYSIS SHEET

1. Committee Title and Meeting Frequency:

   a. Medical Care Evaluation Committee (MCEC);

   b. Monthly and at the call of the chairperson.

2. Committee References:

   a. AR 40400;

   b. HSC Pamphlet 20-1;

   c. HSC Pamphlet 40-1;

   d. JCAH AMH.

3. Committee Cost Factor:

   a. Average cost per meeting: $232.50;

   b Average annual cost: $2790.00.

4. Committee Integration/Coordination:

   a. Receipt of input/feedback: The MCEC receives input regarding MCE matters from the Medical Records Audit Committee and the departments and services of the clinical staff.

   b. Distribution of output/feedback:

      (1) The MCEC routes its minutes to the Executive Committee.

      (2) The MCEC does not route appropriate information to the Credentials Committee for its utilization.

5. Committee Satisfaction of AMEDD/JCAH Requirements/Standards:

   a. AMEDD requirements:

      (1) Generally accomplished.

      (2) The committee Appendix fails to define what represents a quorum IAW HSC Pamphlet 40-1, paragraph 1-1a.

   b. JCAH standards: Acceptable. In view of the new JCAH QA standard, the MCEC needs to assume broader QA responsibilities.

6. Committee Management/Administration Analysis:

a. Reporting mechanisms: See paragraph 4 above.

b. Committee meetings:

(1) The MCEC has difficulties with obtaining a quorum, with tardiness and with early departures.

(2) The MCEC meeting agenda does not reflect in an organized manner the functions for which it is responsible.

c. Committee membership: According to MEDDAC Regulation 15-1 Appendix 2, the MCEC is required to perform utilization review (UR). HSC Pamphlet 40-1 states at paragraph 2-8c that the hospital Executive Officer should also be a committee member. The Executive Officer is not a member of the committee.

d. Committee functions:

(1) Appendix 2 does not parallel that of HSC 40-1, as regards functions of the committee.

(2) Appendix 2, paragraph 3d, refers to the hospital UR plan yet does not make reference as to where it may be found. The MCEC UR functions of Appendix 19, paragraph 6a are not listed in Appendix 2.

(3) Appendix 2, paragraph 3e, makes a vague reference to "statistics" of the departments and services. These statistics are not clarified as to their source, content, utility and purpose. See AR 40-400, Chapter 10.

e. Other:

(1) Paragraph 5 of Appendix 2 does not specify the week, day of week, time of day, and location for the MCEC's monthly meetings.

(2) Currently there is not a primary QAPC for the clearance, review and monitoring of the new QAP for the hospital. QAPC's do not report through the MCEC to the Executive Committee. The MCEC has not consolidated some functions and created sub-committees through which it's mission could be accomplished.

(3) Appendix 2 should contain HSC 20-1 as a reference.

(4) The MCEC Appendix 2 paragraph 3 does not include review responsibilities for Food Services, Social Work Services, the Ambulatory Patient Care Committee and Emergency Medical Care Services Committee.

COMMITTEE ANALYSIS SHEET

1. Committee Title and Meeting Frequency:

   a. Medical Record Audit Committee (MRAC);

   b. Monthly.

2. Committee References:

   a. AR 40-400;

   b. HSC Pamphlet 20-1;

   c. HSC Pamphlet 40-1;

   d. JCAH AMH.

3. Committee Cost Factor:

   a. Average cost per meeting: $122.50;

   b. Average annual cost: $1470.00.

4. Committee Integration/Coordination:

   a. Receipt of input/feedback: Satisfactory.

   b. Distribution of output/feedback:

      (1) The MRAC distributes minutes to the MCEC;

      (2) The MRAC does not distribute minutes to the Credentials Committee for its use in the credentialing process.

5. Committee Satisfaction of AMEDD/JCAH Requirements/Standards:

   a. AMEDD requirements:

      (1) See paragraph 5b below.

      (2) The committee Appendix fails to define what represents a quorum IAW HSC Pamphlet 40-1, paragraph 1-1a.

   b. JCAH standards: A significant improvement is required in the MRAC's procedures for selection of audit topics, diagnoses, procedures. IAW the new JCAH standard on QA, the hospital should study problems which impact upon a significant number of patients. The problems should then be assessed, prioritized with corrective action taken and monitored. Additionally, the MRAC needs to broaden its source of data

retrieval and of problems themselves in order to comply with the numerous other sources enumerated in the QA standard.

6. Committee Management/Administration Analysis:

a. Reporting mechanisms: See paragraph 4b(2) above.

b. Committee meetings:

(1) The MRAC has a history of poor attendance and failure to meet a quorum. Attendance could be improved with regularly scheduled, well-planned and well-coordinated meetings.

(2) The general attitude of the MRAC is in need of examination. Instead of the existing defeatist attitude the MRAC must accept the challenge of being instrumental in the beginning of a new hospital QAP with unlimited possibilities for new QA techniques.

c. Committee membership:

(1) The current membership is in need of examination to determine their interest in and knowledge of the new QAP. Interested members are essential. Their training at JCAH or other QA seminars would be beneficial.

(2) The Patient Administration Division Medical Records Administrator needs to be a member of this committee and should set the pace for its new challenges.

COMMITTEE ANALYSIS SHEET

1. Committee Title and Meeting Frequency:

   a. Therapeutic Agents Board (TAB);

   b. Bi-monthly and at the call of the chairperson.

2. Committee References:

   a. AR 40-2;

   b. AR 40-400;

   c. JCAH AMH, Pharmacy Services;

   d. HSC Pamphlet 40-1.

3. Committee Cost Factor:

   a. Average cost per meeting: $159.50;

   b. Average cost per year: $957.00.

4. Committee Integration/Coordination:

   a. Receipt of input/feedback: Satisfactory.

   b. Distribution of output/feedback:

   (1) Committee minutes are referred to the Executive Committee.

   (2) In view of its drug utilization review findings and monitoring program, committee minutes are not referred to the Credentials Committee and the MCEC.

5. Committee Satisfaction of AMEDD/JCAH Requirements/Standards:

   a. AMEDD requirements:

   (1) Satisfactory.

   (2) The committee Appendix fails to define what represents a quorum IAW HSC Pamphlet 40-1, paragraph 1-1a.

   b. JCAH standards: See paragraph 4b(2) above.

6. Committee Management/Administration Analysis:

   a. Reporting mechanisms: See paragraph 4b(2) above.

b. Committee meetings: Satisfactory.

c. Committee membership: Satisfactory.

d. Committee functions: Satisfactory.

e. Other:

(1) The TAB's Appendix 6 of MEDDAC Regulation 15-1 does not state the month, week of month, day of week, time of day and location of the bi-monthly meetings.

(2) Appendix 6 does not reference AR 40-400 and the JCAH AMH.

COMMITTEE ANALYSIS SHEET

1. Committee Title and Meeting Frequency:

   a. Tumor Board (TB);

   b. Bi-monthly and at the call of the chairperson.

2. Committee References:

   a. AR 40-2;

   b. AR 40-400;

   c. JCAH AMH;

   d. HSC Pamphlet 40-1.

3. Committee Cost Factor:

   a. Average cost per meeting: $107.00;

   b. Average cost per year: $642.00.

4. Committee Integration/Coordination:

   a. Receipt of input/feedback: Appropriate.

   b. Distribution of output/feedback:

   (1) The Board forwards its minutes to the Executive Committee.

   (2) The Board does not forward its minutes to the MCEC.

5. Committee Satisfaction of AMEDD/JCAH Requirements/Standards:

   a. AMEDD requirements:

   (1) The Board does not comply with HSC Pamphlet 40-1, paragraph 3-8a, in that additional ancillary service members are not members and do not participate in "...monitoring the entire spectrum of care for all cancer patients..."

   (2) The committee Appendix fails to define what represents a quorum IAW HSC Pamphlet 40-1, paragraph 1-1a.

   b. JCAH standards: Appropriate.

6. Committee Management/Administration Analysis:

a. Reporting mechanisms: See paragraph 4b(2) above.

b. Committee meetings: The Board has a history of difficulties in obtaining a quorum for its scheduled meetings. Members are routinely late and often leave early.

c. Committee membership: See paragraph 5a above.

d. Committee functions: Satisfactory.

e. Other:

(1) The Board's Appendix 4 to MEDDAC Regulation 15-1 fails to list HSC Pamphlet 40-1 and AR 40-400 as references.

(2) The Board's Appendix 4, paragraph 4, lists the Chief, Department of Pathology as a member twice.

(3) The Appendix 4 does not state in paragraph 3b that Patient Administration Division is responsible for the hospital's Tumor Registry.

COMMITTEE ANALYSIS SHEET

1. Committee Title and Meeting Frequency:

   a. Infection Control Committee (ICC);

   b. Monthly and at the call of the chairperson.

2. Committee References:

   a. AR 40-5;

   b. AR 40-400;

   c. HSC Pamphlet 20-1;

   d. HSC Pamphlet 40-1;

   e. JCAH AMH.

3. Committee Cost Factor:

   a. Average cost per meeting: $142.50;

   b. Average annual cost: $1710.00.

4. Committee Integration/Coordination:

   a. Receipt of input/feedback: The ICC has not established a close liaison with the Safety and Health Committee to include exchange of committee minutes for review and information. This is in contravention to paragraph 2-4e(5) of HSC Pamphlet 40-1.

   b. Distribution of output/feedback:

   (1) The ICC's Appendix 3 to MEDDAC Regulation 15-1 is unclear in that it is not certain to which committee it reports. Paragraph 2a states that the ICC is responsible directly to the Commander, while paragraph 3c states its responsibilities to assit the MCEC.

   (2) The ICC does not forward its minutes for information and review to the Safety and Health Committee nor to the MCEC.

5. Committee Satisfaction of AMEDD/JCAH Requirements/Standards:

   a. AMEDD requirements:

(1) Satisfactory, except for the lack of a liaison between the Safety and Health Committee as per paragraph 4a above.

(2) The committee Appendix fails to define what represents a quorum IAW HSC Pamphlet 40-1, paragraph 1-1a.

b. JCAH standards: Satisfactory.

6. Committee Management/Administration Analysis:

a. Reporting mechanisms: In order for the ICC to fully become incorporated into the hospital's QAP, its minutes must be routed to the MCEC and Safety and Health Committee.

b. Committee meetings: The ICC's meeting schedule is not specified in Appendix 3 with the week of the month, day of week, time of day and location.

c. Committee membership:

(1) The Chief, Microbiology Section is not listed as a member, and yet in fact serves as Recorder.

(2) The Chief, Pharmacy Service is not listed as a member, and yet makes major contributions to the antibiotic usage review program.

(3) The Chief, Professional Services is a member of the committee, and yet is the supervisor and rater of the committee chairperson. This is contrary to all good tenants of committee management.

d. Committee functions: The ICC's Appendix 3 fails to list the functions of antibiotic usage review even though paragraph 5c states that the Antibiotic Review Sub-Committee will be established.

e. Other:

(1) Paragraph 6b(6) and (7) list ICC functions which the Infection Control Nurse (ICN) should be performing, while the ICC monitors the ICN's performance, and reports.

(2) The ICC appendix fails to list the JCAH AMH, HSC Pamphlet 20-1 and HSC Pamphlet 40-1 as references.

(3) The ICC Appendix fails to establish a policy on a quorum as per HSC Pamphlet 40-1, paragraph 1-1a.

COMMITTEE ANALYSIS SHEET

1. Committee Title and Meeting Frequency:

   a. Safety and Health Committee (S&HC);

   b. Monthly and at the call of the chairperson.

2. Committee References:

   a. JCAH AMH;

   b. AR 380-10 with HSC Supplement 1;

   c. MEDDAC Regulation 385-1;

   d. HSC Pamphlet 20-1;

   e. HSC Pamphlet 40-1.

3. Committee Cost Factor:

   a. Average cost per meeting: $102.00;

   b. Average annual cost: $1224.00.

4. Committee Integration/Coordination:

   a. Receipt of input/feedback:

   (1) IAW HSC Pamphlet 40-1, paragraph 2-4e(5), the S&HC has not established liaison with the Infection Control Committee with a mutual exchange of information.

   (2) The S&HC does not always receive appropriate reports of unusual occurrences, DA Form 4106, which involve patient and staff safety, accidents, incidents. See AR 40-400, paragraph 10-12.1c.

   b. Distribution of output/feedback:

   (1) The S&HC's MEDDAC Regulation 15-1 Appendix 20 does not specify to whom or to which activity its minutes should be referred.

   (2) The S&HC does not submit its minutes for review and recommendation for approval through the MCEC to the Executive Committee.

   (3) See paragraph 4a(1) above.

5. Committee Satisfaction of AMEDD/JCAH Requirements/Standards:

a. AMEDD requirements:

(1) Due to the S&HC's lack of compliance with HSC Pamphlet 40-1 paragraph 2-4e(5), a change of procedures is required.

(2) The committee Appendix fails to define what represents a quorum IAW HSC Pamphlet 40-1, paragraph 1-1a.

b. JCAH standards: In view of JCAH's new QA standard on the comprehensive, integrated QAP and plan, changes in procedures as regards receiving and distributing the S&HC's minutes and other information are required.

6. Committee Management/Administration Analysis:

a. Reporting mechanisms: See paragraphs 4 and 5 above.

b. Committee meetings:

(1) The entire committee is not provided with a copy of the committee's agenda. Currently the chairperson and recorder are the sole recipients of agendas.

(2) The specific date and location of the meetings in the S&HC's Appendix 20 is excellent.

c. Committee membership:

(1) The Chief, Professional Services' membership on the committee, in view of his role as supervisor and rater of the committee chairperson, is contrary to the tenants of good committee management. A representative of the Chief, Professional Services would be an adequate substitute.

(2) The S&HC's Appendix 20 paragraph 2c regarding members sending alternates to meetings is excellent.

d. Committee functions. The S&HC's Appendix 20 does not reflect each of the ten safety committee functions listed in HSC Pamphlet 40-1, paragraph 2-4e.

(1) The last phrase of Appendix 20, paragraph 1, needs clarification as regards the absence of the Commander.

(2) The provision for technical consultants to the S&HC, per paragraph 3b of Appendix 20, is excellent.

(3) HSC Pamphlet 40-1 and 20-1 and AR 40-400 are not listed in the references.

COMMITTEE ANALYSIS SHEET

1. Committee Title and Meeting Frequency:

   a. Radiation Control Committee (RCC);

   b. Quarterly or at the call of the chairperson or the RPO.

2. Committee Reference: JCAH AMH Standards on Radiology Services, Nuclear Medicine, Safety and Sanitation.

3. Committee Cost Factor:

   a. Average cost per meeting: $93.50;

   b. Average cost per year: $374.00.

4. Committee Integration/Coordination:

   a. Receipt of input/feedback: The RCC does not receive/review the Safety and Health Committee's minutes.

   b. Distribution of output/feedback:

      (1) MEDDAC Regulation 15-1 does not specify to whom the RCC minutes are to be forwarded.

      (2) The RCC does not closely coordinate with the Safety and Health Committee to include forwarding minutes to both that committee and the MCEC.

5. Committee Satisfaction of AMEDD/JCAH Requirements/Standards:

   a. AMEDD requirements: Satisfactory.

   b. JCAH standards: Satisfactory.

6. Committee Management/Administration Analysis:

   a. Reporting mechanisms: See paragraph 4b above.

   b. Committee meetings: Satisfactory.

   c. Committee membership:

      (1) The RPO and alternate RPO are not both needed on the committee.

(2) The Chief, Microbiology Section and the Chief, Clinical Chemistry are not both needed to serve on the committee, particularly when the Chief, Department of Pathology is also a member.

(3) The MEDDAC Regulation 15-1 fails to specify who will serve as committee recorder.

d. Committee functions:

(1) Some of the committee functions listed more appropriately belong to the RPO, i.e., Appendix 5 to Annex B, paragraph 3h, i, k, l, and o.

(2) Paragraph 3c refers to an "Appendix B" which is not attached.

(3) Paragraph 3a is poorly written. It provides a nebulous description of the RCC's executive sub-committee, its membership and function.

e. Other:

(1) The RCC Appendix 5 fails to indicate the month, week of month, day of week, time of day and location for the committee meetings.

(2) The RCC Appendix 5 fails to list appropriate references for its function. See paragraph 2-13 of HSC Pamphlet 40-1.

COMMITTEE ANALYSIS SHEET

1. Committee Title and Meeting Frequency:

   a. Ambulatory Patient Care Committee (APCC);

   b. Monthly and at the call of the chairperson.

2. Committee References:

   a. APC Model, Chapter 2B;

   b. JCAH AMH;

   c. HSC Pamphlet 20-1;

   d. HSC Pamphlet 40-1.

3. Committee Cost Factor:

   a. Average cost per meeting: $136.00;

   b. Average annual cost: $1632.00.

4. Committee Integration/Coordination:

   a. Receipt of input/feedback: None is described in the APCC Appendix 26 to MEDDAC Regulation 15-1.

   b. Distribution of output/feedback:

   (1) IAW the APCC Appendix 26 APCC minutes are routed to three activities: the Commander, the Chief, Professional Services, and the MCEC.

   (2) The APCC minutes are not shared with the Emergency Medical Care Services Committee and are not routed through the MCEC to the Executive Committee. This is in contravention to HSC Pamphlet 40-1, paragraph 2-15e.

5. Committee Satisfaction of AMEDD/JCAH Requirements/Standards:

   a. AMEDD requirements:

   (1) See paragraph 4b(2) above.

   (2) The committee Appendix fails to define what represents a quorum IAW HSC Pamphlet 40-1, paragraph 1-1a.

b. JCAH standards: See JCAH AMH Hospital-Sponsored Ambulatory Care Services Standard.

6. Committee Management/Administration Analysis:

a. Reporting mechanisms: See paragraph 4 above.

b. Committee meetings: Satisfactory.

c. Committee membership: The APCC Appendix 26 is extremely vague. The membership list includes such nebulous members as "ER," "PAD," "AMIC," "NETS," etc.

d. Committee functions: Satisfactory.

e. Other:

(1) The APCC Appendix 26 does not list the following additional references: JCAH AMH, HSC Pamphlet 20-1, and HSC Pamphlet 40-1.

(2) It is inappropriate for the APCC Appendix 26 to be signed within the context of the MEDDAC Regulation.

COMMITTEE ANALYSIS SHEET

1. Committee Title and Meeting Frequency:

   a. Emergency Medical Care Services Committee (EMCSC);

   b. Quarterly.

2. Committee References:

   a. HSC APC Model #16;

   b. APC Program Document;

   c. JCAH AMH;

   d. HSC Pamphlet 20-1;

   e. HSC Pamphlet 40-1.

3. Committee Cost Factor:

   a. Average cost per meeting: $154.00;

   b. Average annual cost: $616.00.

4. Committee Integration/Coordination:

   a. Receipt of input/feedback: The EMCSC Appendix 12 to MEDDAC Regulation 15-1 does not specify input mechanisms.

   b. Distribution of output/feedback:

      (1) Appendix 12 does not specify output mechanisms.

      (2) IAW HSC Pamphlet 40-1, paragraph 3-6e and 2-15e, the EMCSC should provide minutes and other information to the APCC and the MCEC.

5. Committee Satisfaction of AMEDD/JCAH Requirements/Standards:

   a. AMEDD requirements:

      (1) See paragraph 4a and b above.

      (2) The committee Appendix fails to define what represents a quorum IAW HSC Pamphlet 40-1, paragraph 1-1a.

b. JCAH standards: See the JCAH AMH standards for Special Care Units and Emergency Services.

6. Committee Management/Administration Analysis:

a. Reporting mechanisms: See paragraphs 4 and 5 above.

b. Committee meetings: Satisfactory.

c. Committee membership:

(1) The EMCSC does not comply with HSC Pamphlet 40-1, paragraph 3-6a, where it is specified that when an air ambulance unit is stationed nearby a representative should serve on the committee. There are no members of the 431st Air Medical Detachment listed in the EMCSC Appendix 12.

(2) The Chief, Department of Primary Care and Community Medicine should either not serve on this committee or else should chair it. This is a poor management practice which potentially could inhibit the performance of the committee chairperson and the effectiveness of the committee.

d. Committee functions: The committee functions listed in Appendix 12 should parallel those in paragraph 3-6 of HSC Pamphlet 40-1.

e. Other:

(1) The EMCSC Appendix 12 does not specify the month, week, day of week, time of day and location for its quarterly meetings.

(2) The committee does not document in Appendix 12 its patient care evaluation studies function.

COMMITTEE ANALYSIS SHEET

1. Committee Title and Meeting Frequency:

   a. Utilization Review Committee (URC);

   b. Monthly and at the call of the chairperson.

2. Committee References:

   a. AR 40-400;

   b. HSC Pamphlet 20-1;

   c. HSC Pamphlet 40-1;

   d. JCAH AMH.

3. Committee Cost Factor:

   a. Average cost per meeting: $244.50;

   b. Average annual cost: $3178.50.

   c. Note: This assumes twelve monthly meetings by a centralized URC. The URC is not in fact centralized.

4. Committee Integration/Coordination:

   a. Receipt of input/feedback: Non-applicable.

   b. Distribution of output/feedback: Non-applicable.

   c. Explanation: The URC does not meet as a separate entity despite the manner in which it is presented in the MEDDAC Regulation 15-1. The functions of the URC are detailed to the various QAPC's, thereby creating a decentralized URC.

5. Committee Satisfaction of AMEDD/JCAH Requirements/Standards:

   a. AMEDD requirements:

      (1) The designation of UR functions to the various other QAPC's is acceptable providing those QAPC's meet and address UR at least monthly. This is per HSC Pamphlet 40-1. All of the QAPC's to which UR functions have been delegated meet monthly with the exception of the Emergency Medical Care Services Committee, which meets quarterly, and the TAB, which meets bi-monthly.

(2) The Ireland Army Hospital UR function does not currently meet the AMEDD requirements because not all of the delegated committees address their UR functions in monthly meetings as documented in their minutes.

(3) The committee Appendix fails to define what represents a quorum IAW HSC Pamphlet 40-1, paragraph 1-1a.

b. JCAH standards: The URC does not currently meet JCAH standards for UR for the following reasons:

(1) Appendix 19, which represents the hospital UR plan, has not yet been approved and documented by the MCEC and the Executive Committee.

(2) Not all of the delegated UR functions have been or are being addressed, accomplished, and documented by the UR-delegated QAPC's.

(3) The UR plan does not currently include criteria and length of stay norms for discharge planning.

(4) There is no coordinated effort between the medical and nursing staff as regards discharge planning.

6. Committee Management/Administration Analysis:

a. Reporting mechanisms: See paragraph 4c above.

b. Committee meetings: See paragraph 4c above.

c. Committee membership: Were the URC to become an active, centralized committee, without the delegation of its UR functions, the committee membership would be appropriate. In view of the current delegation of UR functions, there is inadequate involvement of key administrative personnel such as the Executive Officer, the Chief, Logistics Division, and the Comptroller.

d. Committee functions:

(1) See paragraph 4c and 5a above.

(2) MEDDAC Regulation 15-1 does not include the delegated UR functions in the function lists of each appropriate QAPC. Additionally, the delegated UR committees are not required to include their UR functions on their agendas and committee minutes to insure that the appropriate action is taken. Further, the MCEC does not review the delegated URC's minutes on a monthly basis.

e. Other:

(1) Appendix 19 does not include the appropriate UR references as per paragraph 2 above. Additional written guidance from HSC is not included, i.e., See HSC letter (HSOP-PR), dated 9 November 1977, "UR Program."

(2) Appendix 19, the hospital UR Plan, needs to be rewritten so as to delegate the UR functions in such a manner that the delegated UR QAPC's will be closely coordinated and monitored.

COMMITTEE ANALYSIS SHEET

1. Committee Title and Meeting Frequency:

    a. Rabies Advisory Board (RAB);

    b. At the call of the chairperson.

2. Committee References:

    a. AR 40-5, Health and Environment;

    b. AR 40-418, Medical Statistical Reporting;

    c. AR 40-655, Prevention and Control of Communicable Diseases in Animals;

    d. USAARMC Regulation 40-18, Rabies Prevention;

    e. USAARMC Regulation 40-12, Control of Animals;

    f. Kentucky Revised Statute (KRS), Chapter 257, 258.000 through 258.990;

    g. Recommendations of the Public Health Service Advisory Committee on Immunization Practices, Rabies, April 1977.

3. Committee Cost Factor:

    a. Average cost per meeting: $51.00;

    b. Average cost per year assuming four meetings: $204.00.

4. Committee Integration/Coordination:

    a. Receipt of input/feedback: Of necessity, this is excellent.

    b. Distribution of output/feedback:

        (1) Output/feedback to the attending physician is excellent.

        (2) Output/feedback should be considered for expansion to the MCEC.

5. Committee Satisfaction of AMEDD/JCAH Requirements/Standards:

    a. AMEDD requirements:

        (1) Satisfactory.

(2) The committee Appendix fails to define what represents a quorum IAW HSC Pamphlet 40-1, paragraph 1-1a.

b. JCAH standards: Satisfactory.

6. Committee Management/Administration Analysis:

a. Reporting mechanisms: MEDDAC Regulation 15-1 Appendix 21 does not state to whom the Board's minutes are reported. Its feedback is immediately received by the attending physician, but it is unknown as to whether the MCEC or Executive Committee also receive the input.

b. Committee meetings: Satisfactory.

c. Committee membership: Appropriate.

d. Committee functions: Appropriate.

e. Other: The references listed are excellent.

COMMITTEE ANALYSIS SHEET

1. Committee Title and Meeting Frequency:

   a. Medical Library Committee (MLC);

   b. Quarterly.

2. Committee References:

   a. AR 40-2;

   b. HSC Pamphlet 20-1;

   c. HSC Pamphlet 40-1;

   d. JCAH AMH.

3. Committee Cost Factor:

   a. Average cost per meeting: $113.00;

   b. Average cost per year: $452.00.

4. Committee Integration/Coordination:

   a. Receipt of input/feedback: Satisfactory.

   b. Distribution of output/feedback: Satisfactory.

5. Committee Satisfaction of AMEDD/JCAH Requirements/Standards:

   a. AMEDD requirements:

      (1) Satisfactory.

      (2) The committee Appendix fails to define what represents a quorum IAW HSC Pamphlet 40-1, paragraph 1-1a.

   b. JCAH standards: Satisfactory.

6. Committee Management/Administration Analysis:

   a. Reporting mechanisms: Satisfactory.

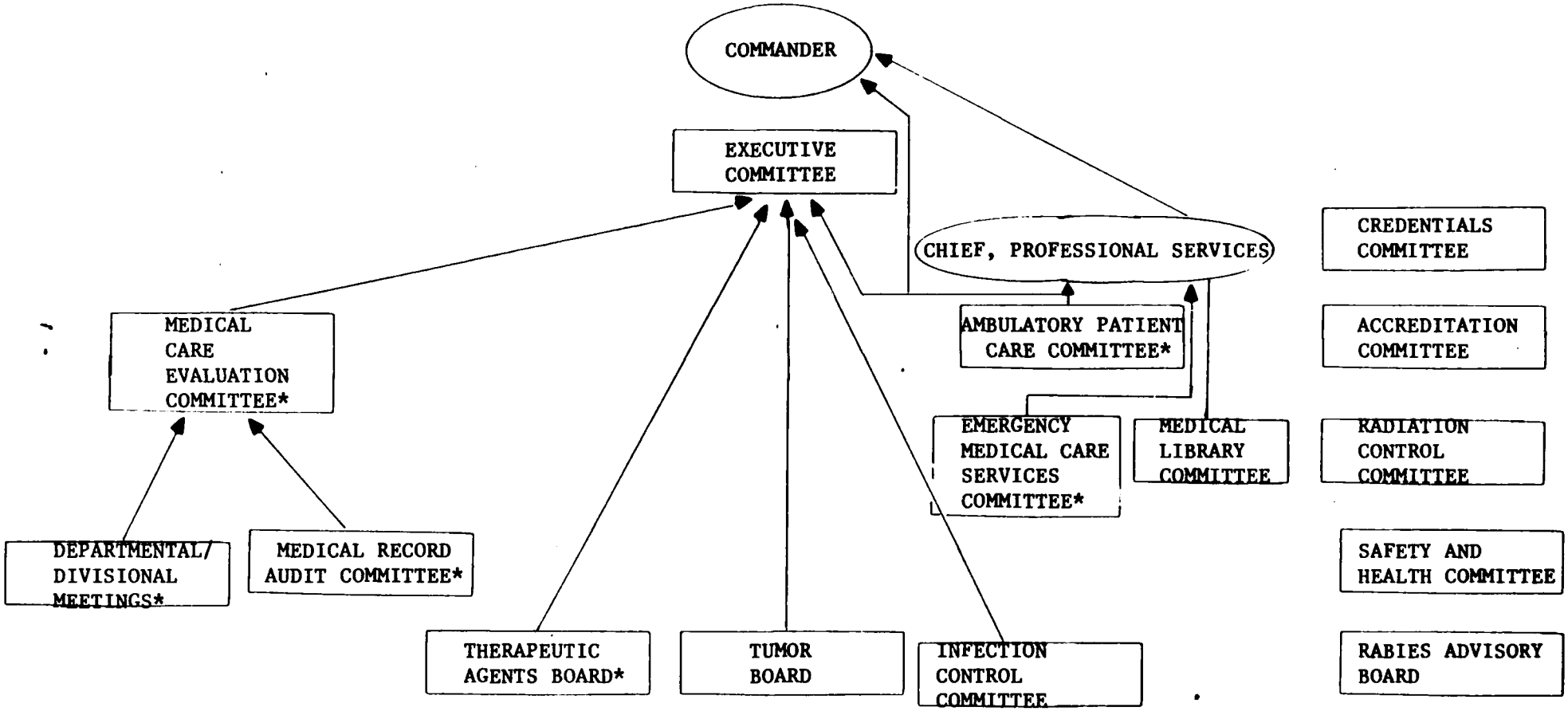
   b. Committee meetings: Satisfactory.

   c. Committee membership: A representative of hospital administration is not a member. This is necessary in order to represent the hospital administration interests in the Library.

   d. Committee functions: Satisfactory.

e. Other: A procedural improvement is required which would not only streamline the committee's procedures for approval and acquisition of materials, but would minimize the duration of meetings: The Medical Librarian should, upon receipt of a requisition, review it for appropriateness and completeness, and then, using an overprint Disposition Form (DF), DA Form 2496, route the basic information from the request through the committee membership via the message center. Upon return of the overprint DF, the Medical Librarian would total the committee's votes for approval/disapproval and then either initiate the appropriate logistical coordination or return the request to its originator. This change in procedure would prevent the existing delays inbetween quarterly committee meetings, which are in addition to the usual purchasing and contracting delays.

CURRENT QUALITY
ASSURANCE PROGRAM
COMMITTEE STRUCTURE



NOTE: The Utilization Review Committee functions are performed by those committees marked with an asterisk.*

(Source: MEDDAC Regulation 15-1, "Boards, Councils and Committees," with Change 1 dated 5 February 1980.)

APPENDIX F

CURRENT

QUALITY ASSURANCE

PROGRAM COMMITTEE

STRUCTURE

CURRENT
QUALITY ASSURANCE PROGRAM
COMMITTEE STRUCTURE
MEMBERSHIP MATRIX

COMMITTEE MEMBERS	COMMITTEES														
	EC	CC	HAC	MCEC	MRAC	TAB	TB	ICC	S&HC	RCC	APCC	EMCSC	URC	RAB	MLC
CDR	XXX														
C,PS	X	XXX/(XX)	XXX	XXX		XXX		X	X	XXX			XXX		
XO	X		X										X		
C,DoN	X	X		X	X	X		X	X			X	X		
ADMIN RES	XX		X												
C,D MED		X		X	X	X	X	X		X		X	X	X	X
C,D SURG		X		X	X	X	X	X				X	X		
C,D PCCM		X		X	XXX	X					XXX	X/(XX)	X		
C,NP				X		X							X		X
C,PAD			X	XX			X				X		X		
C,D PATH				X			XXX			X			X		X
C,D RAD				X			X			X			X		X
C, PHARM		(X)		X	X	XX						X	X		
C, PMA								XXX	XXX					XXX/XX	X
C, OR								X							
C, CMS								X							
C, FD SVC								X	X						
C, SVC BR								X							
C, PED					X	X		X						X	
ICN						X		X	(X)						
C,D DENT						X	X								
C, NUC MED										X					
RPO									(X)	X					
ALT RPO										X					
C, MICRO										X					
C, CL CHEM										X					
C, MED MAINT									(X)	X					
SAFETY OFF									XX	X					
C, LOG						X			X				X		
C, OB/GYN					X	X									
C, OPTHAL		X				X									
C, GEN SURG															XXX

	EC	CC	HAC	MCEC	MRAC	TAB	TB	ICC	S&HC	RCC	APCC	EMCSC	URC	RAB	MLC
PROP BK OFF															(X)
MED LIBRARIAN															XX
C,EMS												XXX			
C,CARD												X			
C,ANES												X			
C,CSD			X						X		X	X			
HN, ER												X			
HN, ICU/CCU												X			
C, EMT's												X			
C, ORTHO					X										
PAD MRT's					XX		(XX)								
COMPT													X		
C, PERS									X						
C, PCCN											X				
C, CAS											X				
C, OPR											X				
PT REP											X				
C, NETS											X				X
C, MED RECP											X				
C, AMIC											X				
C, AMBL											X				
ER											X				
MEETING FREQUENCY	D	At Call	At Call	M	M	BI-M	BI-M	M	M	Q	M	Q	M	At Call	Q

CODES:

XXX = Committee Chairperson
XX = Committee Recorder
X = Committee Member
(XX) = Representative is Committee Recorder or Recorder without vote
(X) = Committee Member as needed or without vote

D = Daily
M = Monthly
Q = Quarterly
Bi-M = Bi-monthly

APPENDIX G

IRELAND ARMY HOSPITAL COMMITTEE QUESTIONNAIRE AND LIST OF STAFF MEMBERS POLLED

DISPOSITION FORM

For use of this form, see AR 340-15, the proponent agency is TAGCEN.

REFERENCE OR OFFICE SYMBOL	SUBJECT
ATZK-MD	IAH Committee Questionnaire

TO

FROM Admin Resident
USA MEDDAC

DATE 24MAR80 CMT 1
/pep/9825

1. As the Hospital's 1979-80 Health Care Administrative Resident, I am conducting a major problem-solving research project which focuses on the hospital's committee structure and its associated procedures. Following an indepth analysis of the existing situation, my goal is to redesign the IAH committee structure so as to (1) maximize the productive time of the clinical and administrative staff, (2) maximize committee coordination and interrelated functions, as appropriate; and (3) satisfy the requirements and standards of the AMEDD and JCAH. My study will be limited to committees which primarily impact IAH as a whole. Departmental and divisional committees will not be addressed. Orientations, briefings and general staff conferences will also not be addressed.

2. I would sincerely appreciate your assistance with my project by your candid completion of the attached questionnaire, Inclosure 1. I can assure you that your responses will be held in strictest confidence.

3. Your cooperation and assistance will be greatly appreciated. I look forward to your comments and innovative ideas.

4. Please return the questionnaire to me not later than ~~28 March~~ 4 APR 1980. If you have any questions or comments, please call me at 624-9825.

Allan R. Threet

1 Incl
as

ALLAN R. THREET
Captain, MSC
Admin Resident

DA FORM 1 FEB 67 2496 REPLACES DD FORM 96, WHICH IS OBSOLETE.

Ireland Army Hospital Committee Questionnaire

1. Demographic Information.

   a. Name: _____

   b. Rank: 01 02 03 04 05 06

   c. Branch: MC MSC ANC VC DC AMSC

   d. Duty position: _____

2. Please list the committees of which you are currently a member. Please indicate whether or not you are the chairperson, or recorder, and how long you've been a member of the committee. Use the reverse of this page as necessary.

	COMMITTEE NAME	CHAIRPERSON/RECORDER	LENGTH OF TIME
a.			
b.			
c.			
d.			
e.			
f.			

3. Have you received a briefing concerning your responsibilities within the above committee(s) as a -

   a. Member ?

   b. Recorder ?

   c. Chairperson ?

   d. Please explain: _____

_____

_____

_____

4. Have you received a briefing as to the mission or purpose of these committee(s)?

a. Yes No

b. Please explain:_____

_____

_____

_____

_____

5. In your opinion do these committee(s) accomplish their mission(s)?

a. Yes No

b. Please explain:_____

_____

_____

_____

_____

6. In your opinion how could these committee(s) be improved?

a. Meet less frequently?_____

b. Meet more frequently?_____

c. Meet at a different time of day._____

d. Meet on a different day of the week._____

e. Other._____

f. Please explain your answers:_____

_____

_____

_____

_____

_____

7. How much time does it take you on the average to go to and from your committee meetings? Check one.

a. 0-5 minutes._____

b. 6-15 minutes._____

c. 16-30 minutes._____

d. Other._____

e. Please explain._____

_____

_____

_____

8. IAH Committee membership is currently determined by a person's position. Do you feel that this enhances the committee's effectiveness? Please explain._____

_____

_____

_____

9. Which method or methods would you prefer for committee membership selection? Check your preference.

a. Appointment by position._____

b. Appointment by supervisor based on individual's interests/ preference._____

c. Election by peers._____

d. Other._____

e. Please explain your preference._____

_____

_____

_____

10. Would you agree with having one or two days of each month blocked-out for committee meetings? This could include clinic appointments and surgery schedules.

a. Yes_____

b. No_____

11. If yes, what time period of the month would you recommend?

a. 1st week_____ c. 3rd week_____

b. 2nd week_____ d. 4th week_____

12. Would you agree to having meeting times scheduled to coincide with a meal time?

a. Yes_____ No_____

b. Please explain:_____

_____

_____

13. If yes, which would you prefer?

a. Breakfast (0630 - 0730).____

b. Lunch (1200 - 1300).____

c. Dinner (1730 - 1800).____

d. Comments:_____

_____

14. If you were the chairperson of a committee, what would be your policy as concerns the following?

a. Attendance._____

_____

b. Sending a representative when the member can't attend.___

_____

_____

c. Preparation for the meeting._____

_____

d. Agenda preparation._____

_____

e. Minutes._____

_____

f. Starting on time or waiting for everyone._____

_____

g. Other._____

_____

_____

h. Please explain._____

_____

_____

_____

15. Many times committees act or react without full knowledge of their limitations or of other committees' missions/actions. Many committees perform similar functions without benefit of coordination or integration. What changes would you recommend in the IAH committee structure in order to correct this? Please be specific:_____

_____

_____

_____

16. The new Quality Assurance Standard in the 1980 JCAH Accreditation Manual for Hospitals requires a comprehensive, integrated Quality Assurance Program. Please share your ideas about how this hospital's Quality Assurance Program might satisfy this standard through existing or new committees, while maximizing staff productivity:_____

_____

_____

_____

_____

LIST OF STAFF MEMBERS POLLED

1. Commander
2. Executive Officer
3. C, Professional Services
4. Adjutant
5. C, Patient Administration Division
6. C, Clinical Support Division
7. C, Plans, Operations and Training Division
8. C, Comptroller Division
9. C, Logistics Division
10. C, Food Services Division
11. C, Personnel Division
12. C, Department of Medicine
13. C, Department of Surgery
14. C, Department of Psychiatry
15. C, Department of Pathology
16. C, Department of Primary Care and Community Medicine
17. C, Department of Nursing
18. C, Pharmacy Service
19. C, Pediatric Service
20. C, Internal Medicine Service
21. C, General Surgery Service
22. C, Orthopedic Service
23. C, Urology Service
24. C, Nuclear Medicine Service
25. C, Obstetrics/Gynecology Service
26. C, Service Branch
27. C, Medical Record Administration Branch
28. Command Sergeant Major
29. C, Nursing Education and Training Service
30. C, Primary Care and Community Nursing
31. Infection Control Nurse
32. C, Preventive Medicine Activity
33. C, Social Work Service
34. C, Emergency Medical Service
35. Medical Coordinator, Department of Nursing
36. Surgical Coordinator, Department of Nursing
37. C, Ophthalmology Service
38. C, Force Development Division
39. XO, Preventive Medicine Activity
40. C, Community Mental Health Activity
41. Assistant C, Clinical Support Division
42. Supervisor, Medical Receptionists
43. Health Facility Project Officer
44. Assistant C, Department of Nursing
45. Radiation Protection Officer

APPENDIX H

RESOURCES MANAGEMENT COMMITTEES

ALTERNATIVES AND EVALUATION

DECISION MATRIX

RESOURCES MANAGEMENT COMMITTEES
ALTERNATIVES AND EVALUATION
DECISION MATRIX

RMC ALTERNATIVES	CRITERIA			
	COST FACTOR	INTEGRATION AND COORDINATION	SATISFACTION OF AMEDD/JCAH	TOTAL
1. Status Quo	0	0	1	1
2. Alter Reporting Mechanisms	0	1	1	2
3. Consolidate Meeting Schedules	2	2	2	6
4. Consolidate Committees	2	3	3	8
5. Combination of 2, 3 and 4	3	3	3	9

CODE:

0 = Fails to meet criteria
1 = Meets criteria
2 = Exceeds criteria

APPENDIX I

QUALITY ASSURANCE PROGRAM COMMITTEES

ALTERNATIVES AND EVALUATION

DECISION MATRIX

QUALITY ASSURANCE PROGRAM COMMITTEES
ALTERNATIVES AND EVALUATION
DECISION MATRIX

QAPC ALTERNATIVES	CRITERIA			
	COST FACTOR	INTEGRATION AND COORDINATION	SATISFACTION OF AMEDD/JCAH	TOTAL
1. Status Quo	0	0	1	1
2. Alter Reporting Mechanisms	0	1	1	2
3. Consolidate Meeting Schedules	2	2	2	6
4. Consolidate Committees	2	3	3	8
5. Combination of 2, 3 and 4	3	3	3	9

CODE:

0 = Fails to meet criteria
1 = Meets criteria
2 = Exceeds criteria

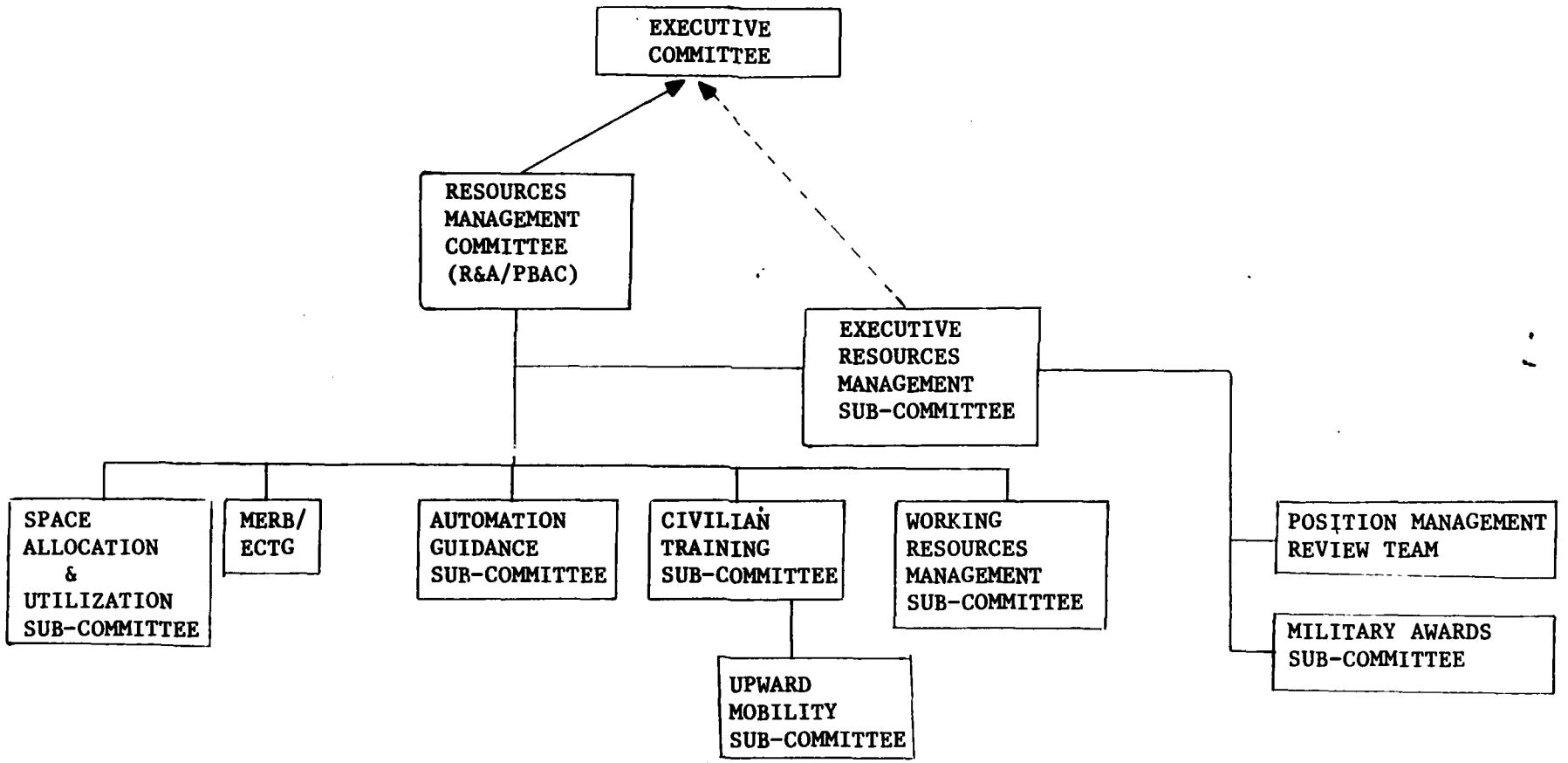
APPENDIX J

OPTIMUM FEASIBLE

RESOURCES MANAGEMENT COMMITTEE

STRUCTURE

OPTIMUM FEASIBLE
RESOURCES MANAGEMENT COMMITTEE
STRUCTURE



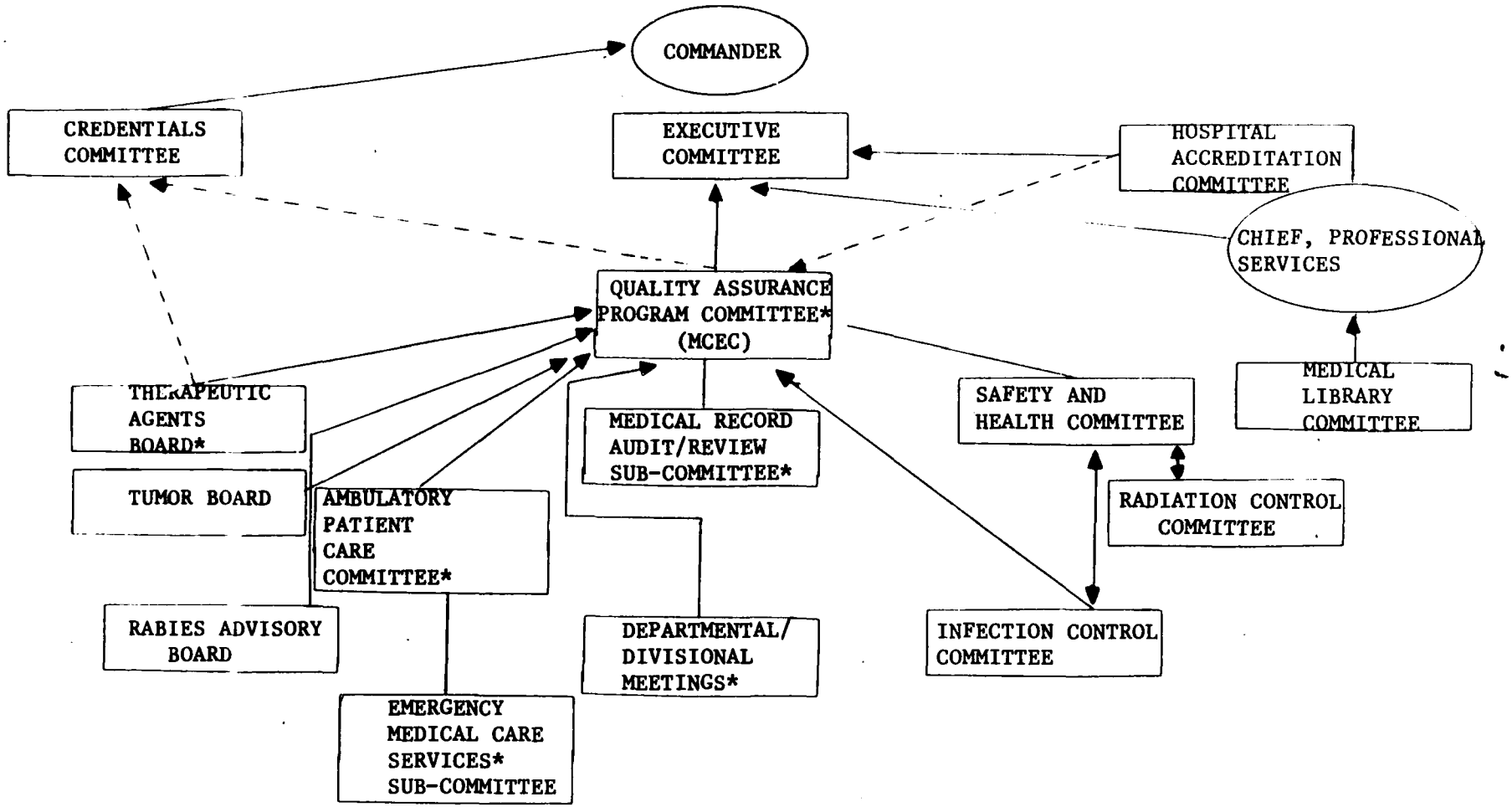
APPENDIX K

OPTIMUM FEASIBLE

QUALITY ASSURANCE PROGRAM COMMITTEE

STRUCTURE

OPTIMUM FEASIBLE
QUALITY ASSURANCE PROGRAM COMMITTEE
STRUCTURE



NOTE: The decentralized Utilization Review Committee functions are performed by those committees marked with an asterisk.*

APPENDIX L

DEFINITION OF

COMMITTEE LEADERSHIP/

MEMBERSHIP

ROLES

DEFINITION OF COMMITTEE LEADERSHIP/MEMBERSHIP ROLES

1. The committee Chairperson has responsibilities to:

a. Effectively lead the committee by generating an interest or desire on the part of the committee members to accomplish the committee's mission;

b. Maintain control of the committee meeting by keeping the discussion on track and within the allotted time limitations;

c. Objectively guide the committee's decision-making process and mediate the discussion so as to minimize conflict and maximize the committee's productive synergy;

d. Assist the Recorder with the preparatory actions prior to each meeting to include development of an agenda;

e. Insure that new committee members have been properly oriented as to the committee's mission and functions as well as the Chairperson's expectations of the committee member;

f. Insure the overall effectiveness of the committee by minimizing the wasting of members' time and maximizing of the committee's productivity.

2. The committee Recorder has responsibilities to:

a. Assist the Chairperson in preparations for the committee's meetings to include development of a brief, concise agenda;

b. Insure that all committee members have been reminded of the committee meeting by forwarding a reminder note, publishing daily bulletin reminders, calling the members on the morning of the meeting, and announcing the meeting over the hospital intercom shortly prior to its commencement;

c. Maintain committee minutes which are brief, concise, accurate, complete as well as finalized and distributed in a timely manner;

d. Remind committee members of their action responsibilities as well as the suspense dates established for those actions;

e. Insure that incomplete actions are carried-over as old business within the committee meeting agenda and minutes until their proper completion;

f. Assist the Chairperson by helping to steer the committee discussion back on track when it is appropriate;

g. Assist the Chairperson to summarize the committee's recommendations and actions by recounting the specific what, who, how and when information for the committee minutes.

h. Assist the Chairperson to conduct a proper orientation of new committee members;

3. The committee Member has responsibilities to:

a. Attend committee meetings on time and in a state of preparation;

b. Assist the Chairperson by helping to steer the committee discussion back on track when it is appropriate;

c. Refrain from monopolizing the committee discussion by allowing fellow committee members to express themselves;

d. Relay the committee's information, recommendations and actions to the member's colleagues or staff in order that the committee business may, as appropriate, enable the maximum number of personnel to be informed;

e. Appoint and send an interested, knowledgeable, informed and prepared replacement when absence from a committee meeting is unavoidal .

APPENDIX M

COMMITTEE MEETING

PREPARATION

PROGRAM EVALUATION REVIEW TECHNIQUE (PERT)

CHART

COMMITTEE MEETING PREPARATION PROGRAM EVALUATION REVIEW TECHNIQUE (PERT) CHART

The following is intended to represent an example of the ideal sequence of events which should preceed and follow a standard monthly committee meeting:

ACTIVITY #	TIME FACTOR	ACTIVITY	RESPONSIBLE AGENT
1.	M - 14 days	Insure that the meeting site is reserved.	Recorder
2.	M - 7 days	Coordinate the meeting agenda.	Recorder/Chairperson
3.	M - 5 days	Distribute a reminder notice with a tentative agenda.	Recorder
4.	M - 3 days	Publish daily bulletin reminders.	Recorder
5.	M - 2 days	Finalize the meeting agenda.	Recorder/Chairperson
6.	M - 4 hours	Telephone each member to remind them of the meeting.	Recorder
7.	M - .5 hour	Announce the meeting reminder on the hospital intercom.	Recorder
8.	M	Document the meeting.	Recorder
9.	M + 5 days	Submit the minutes to the Chairperson.	Recorder
10.	M + 10 days	Submit the minutes to the next higher committee.	Recorder/Chairperson
11.	M + 10 days	Distribute the minutes to the committee membership.	Recorder
12.	M + 14 days	Remind the committee members of action responsibilities.	Recorder/Chairperson

ACTIVITY #	TIME FACTOR	ACTIVITY	RESPONSIBLE AGENT
13.	M - 14 days	Insure that the meeting site is reserved.	Recorder
14.	M + 21 days	Receive and evaluate the next higher committee's review and recommendations of the committee minutes.	Recorder/Chairperson
15.	M - 7 days	Repeat activity numbers 1-14.	As appropriate

CODE:

M = Meeting
\- = Minus or before
\+ = Plus or after

APPENDIX N

PROPOSED FORMAT

FOR COMMITTEE

MINUTES

(EXAMPLE)

ATZK-MD ( ) 1st Ind
SUBJECT: Review of (Committee Title) Minutes for 18 November 1980

HEADQUARTERS, US ARMY MEDICAL DEPARTMENT ACTIVITY, Fort Knox, Kentucky 40121

TO: Chairperson, (Committee Title), Ireland Army Hospital Fort Knox, KY 40121

1. The subject minutes were reviewed and approved by the Executive Committee on 29 November 1980.

2. The Executive Committee makes the following comments about the (Committee Title) Committee's recommendations:

a. Recommendation one is approved as recorded.

b. Recommendation two is approved pending the committee's submission to resource requirements anticipated for its implementation.

c. Recommendation three is disapproved, IAW AR 40- paragraph 6-9f.

3. The Executive Committee makes the following observations concerning the (Committee Title) Committee's activities:

a. The fulfillment of the Utilization Review function of the Committee per MEDDAC Regulation 15-1, Appendix 7 was not documented in the 18 November 1980 minutes. The committee will address this function more explicitly in future meetings and supporting documents.

b. The (Committee Title) Committee barely satisfied its established quorum requirement. In addition, several absent members failed to send alternate representatives to the committee meeting. The committee chairperson will insure that all committee members receive adequate notification of committee meetings and, if unavoidable, send informed and prepared representatives in their place.

_____
COL, MC
Commanding

(EXAMPLE)

DEPARTMENT OF THE ARMY
US ARMY MEDICAL DEPARTMENT ACTIVITY
Fort Knox, Kentucky 40121

ATZK-MD

SUBJECT: (Committee Title) Committee Minutes, 18 November 1980

THRU: Chairperson
Medical Care Evaluation Committee
Ireland Army Hospital
Fort Knox, Kentucky 40121

TO: Executive Committee
Ireland Army Hospital
Fort Knox, Kentucky 40121

1. The monthly meeting of the (Committee Title) Committee was convened at 1300 hours on 18 November 1980 in the Headquarters Conference Room.

2. Meeting Attendance:

a. The following members or their representatives were present:

(1) COL _____, MC (Chairperson), C, Department of _____;

(2) LTC _____, MC (Representative), C, Department of _____;

(3) MAJ _____, MSC (Recorder), C, _____ Division.

b. The following members were absent:

(1) COL _____, MC (TDY), C, Department of _____;

(2) 2LT _____, MSC (Unexcused), _____.

c. Others in attendance were:

(1) MAJ _____, AMSC, C, _____;

ATZK-MD
SUBJECT: (Committee Title) Committee Minutes, 18 November 1980

(2) Mr. _____, GS-10, _____.

3. Old business is recorded at Inclosure #1.

4. New business is recorded at Inclosure #1.

5. Committee recommendations are recorded at Inclosure #1.

6. The meeting adjourned at 1400 hours and will next meet at 1300 hours on 18 December 1980 in the Headquarters Conference Room.

1 Incl
Record of Committee Proceedings

_____
COL, MC
Chairperson

_____
MAJ, MSC
Recorder

Cy Furn:
1 - Each Person Listed at paragraph 2 above
3 - Each - Recorder, Medical Care Evaluation Committee

(EXAMPLE)

RECORD OF COMMITTEE PROCEEDINGS

MINUTES OF THE: (Committee Title)

DATE: 18 Nov 1980

NO.	EXPLANATION	Update	THIS ITEM IS FOR: Info	Action-Suspens	
3.	OLD BUSINESS:				
a.	Item 1.	X	C,PAD		
b.	Item 2.	X			
4.	NEW BUSINESS:				
a.	Committee Function 1:	X			
b.	Committee Function 2:	X			
5.	RECOMMENDATIONS:				
a.	Recommendation 1:			C,PAD	1Jan8
b.	Recommendation 2:			Infec-tion Control Nurse	2Jan8

ATZK-MD Form 217 (1Jan80)

APPENDIX O

PROPOSED FORMAT

FOR COMMITTEE

MEETING AGENDAS

(EXAMPLE)

(Committee Title) COMMITTEE
MEETING AGENDA

1300 hours, 18 November 1980
HQ'S Conference Room

TIME	SUBJECT	RESPONSIBILITY
1300 hours	1. Purpose of Meeting	Chairperson
	a.	
	b.	
	c.	
1305 hours	2. Old Business	Chairperson
1315 hours	3. New Business	Chairperson
	a. Committee Function 1	C, PAD
	b. Committee Function 2	C, CSD
	c. Committee Function 3	Recorder
1350 hours	d. Other New Business	Chairperson
1355 hours	4. Summary of Committee Recommendations, Action Responsibilities, Suspense Requirements	Chairperson/ Recorder
1359 hours	5. Reminder of next committee meeting at 1300 hours on 18 December 1980 in the HQ's Conference Room	Chairperson

APPENDIX P

PROPOSED OUTLINE

FOR COMMITTEE

LEADERSHIP

TRAINING PROGRAM

PROPOSED OUTLINE FOR COMMITTEE LEADERSHIP TRAINING PROGRAM

I. INTRODUCTION

A. Importance of Committees:

1. Dominant management mechanism in business;

2. Dominant management mechanism in health care administration;

(a) AMEDD requirements;

(b) JCAH standards.

3. Committee disadvantages;

4. Committee advantages;

B. Importance of Leadership Roles:

1. Chairperson;

2. Recorder.

C. Importance of Optimum Committee Efficiency:

1. Membership costs;

2. Loss of productive, workload producing capability;

3. Accomplishment of committee mission.

II. DISCUSSION

A. Definition of Committee Membership Roles:

B. Definition of Committee Leadership Roles:

1. The Chairperson;

2. The Recorder.

C. Committee Management:

1. Clarity of committee mission/purpose;

2. Committee size;

3. Membership selection;

4. Committee preparation;

5. Committee administration.

D. Organizational Behavior and Group Dynamics:

1. The committee as a group;

2. The individual roles within the committee;

3. Seating arrangements;

4. Control techniques.

E. Practical Exercise:

III. CONCLUSION

A. Summarization:

1. Importance of:

(a) Committees;

(b) Leadership roles;

(c) Optimum committee efficiency;

2. Definition of leadership roles;

3. Committee management;

4. Organizational behavior and group dynamics.

B. Training Program Evaluation:

BIBLIOGRAPHY

BIBLIOGRAPHY

Books

Banner, Hubert, Group Dynamics, The Ronald Press Company, N.Y., 1959.

Bliss, Edwin C., Getting Things Done, Bantam Books, N.Y., 1978.

Carnegie, Dale, How to Save Time and Get Better Results in Conferences, Dale Carnegie & Associates, Inc., Garden City, N.Y., 1974.

Caplow, Theodore, How to Run Any Organization, Holt, Rinehart and Winston, N.Y., 1976.

Cerami, Charles A., Successful Management: Managing Yourself, Your People and Your Business, Doubleday & Co., Inc., Garden City, N.Y., 1964.

Cooper, Joseph D., How to Get More Done in Less Time, Doubleday & Co., Inc., Garden City, N.Y., 1971.

Cunningham, Robert M., Jr., Governing Hospitals: Trustees and the New Accountabilities, AHA, Chicago, IL., 1976.

Dale, Ernest and Urwick, Lyndall F., Staff in Organization, McGraw-Hill Book Co., N.Y., 1960.

Drucker, Peter F., Management: Tasks - Responsibilities - Practices, Harper & Row, Publishers, N.Y., 1974.

Durbin, Robert, Human Relations in Administration, 4th Ed., Prentice-Hall, Inc., Englewood Cliffs, N.J., 1974.

Eisele, C. Wesley, ed. The Medical Staff in the Modern Hospital, McGraw-Hill Book Co., N.Y., 1967.

Gardner, Neely D., Effective Executive Practices, Doubleday & Co., Inc., Garden City, N.Y., 1963.

Glos, R. E. and Baker, Harold, Business: Its Nature and Environment, South-Western Pub. Co., Chicago, 1972.

[illegible]ller, Robert M., The New Management, Macmillan Publishing Co., Inc., N.Y., 1974.

[illegible]mann, Theo, Supervisory Management for Health Care Institutions, The Catholic Hospital Association, St. Louis, MO., 1973.

[illegible]. S., Human Communication, Harper & Row, Publishing Co., N.Y., 1974.

Hicks, Herbert G., The Management of Organizations: A System and Human Resources Approach, 2d Ed., McGraw-Hill Book Co., N.Y., 1972.

Koontz, Harold, Appraising Managers as Managers, McGraw-Hill Book Co., N.Y., 1971.

Koontz, Harold and O'Donnell, Cyril, Essentials of Management, McGraw-Hill Book Co., N.Y., 1974.

Koontz and O'Donnell, Management: A Book of Readings, 4th Ed., McGraw-Hill Book Co., N.Y., 1976.

Koontz, Harold and O'Donnell, Cyril, Principles of Management: An Analysis of Managerial Functions, McGraw-Hill Book Co., N.Y., 1968.

Koontz, and O'Donnell, Principles of Management: An Analysis of Managerial Functions, 5th Ed., McGraw-Hill Book Co., N.Y., 1972.

Letourneau, Charles V., The Hospital Administrator, Starling Publications, Chicago, IL., 1969.

Lippitt, Gordon L., Optimizing Human Resources: Readings in Individual and Organizational Development, ed. Gordon L. Lippitt, Leslie E. and Robert G. Bidwell Jr., Addison-Wesley Publishing Co., Menlo Park, CA, 1971.

McGibony, G. P., Principles of Hospital Administration, 2d Ed., Putnam & Sons, N.Y., 1969.

Newman, William H. and Logan, James P., Strategy, Policy, and Central Management, 6th Ed., South-Western Publishing Co., Cincinnati, OH, 1971.

Newman, William H.; Summer, Charles E.; and Warren, E. Kirby, The Process of Management, 2d Ed., Englewood Cliffs, N.J., 1967.

Newport, M. Gene, The Tools of Managing, Addison-Wesley Publishing Co., Reading, Mass., 1972.

Phillips, David C., Oral Communication in Business, McGraw-Hill Book Co., N.Y., 1955.

Robinson, Geoffrey A., Hospital Administration, 2d Ed., Butterworth & Co., Ltd., London, 1966.

Sloan, Alfred P. Jr., My Years with General Motors, ed. John McDonald and Catherine Stevens, Doubleday & Co., Inc., Garden City, N.Y., 1972.

The Arco Editorial Board, Supervision Course: A Quizzer and Guide for Civil Service and Business, ARCO, N.Y., 1967.

VanDersal, William R., The Successful Manager in Government and Business, Harper & Row, Publishing, N.Y., 1974.

Periodicals

Affeldt, John E., "Accreditation Problems: Quality Assurance Standard Issued," Hospitals, 16 December 1979, pp. 15.

"An Explanation of the New Quality Assurance Standard," Perspectives on Accreditation, May/June 1979, pp. 7-9.

Ashbaugh, David G. and McKean, Robert S., "The Philosophy and Use of Audit," Journal of the American Medical Association, Vol. 236, 27 September 1976, pp. 1488.

Baldwin, L. Eugene, "An Empirical Study: The Effect of Organizational Differentiation and Integration on Hospital Performance," Research in Hospital Management, 14 October 1978.

Balfanz, Dorothy, "It All Begins with the Nominating Committee," Trustee, September 1979, pp. 22-23, 26-28.

Barr, Daniel M., Wollstadt, Loyd J., and Kinast-Porter, Susan, "Communications: Will Physicians Learn to Like Quality Assurance? The Effect of a Curriculum on Medical Student Attitudes," Journal of Medical Education, 10 April 1980, pp. 649-650.

Bauerschmidt, Alan D., "The Hospital as a Prototype Organization," Hospital and Health Services Administration, Vol. 15, No. 2, Spring 1970, pp. 6-14.

Best, J. B.; Davenport, P. G.; Swinden, L. B.; and Yeatman, J. S., "Participative Management: The Action Committee," The Medical Journal of Australia, 28 September 1974, pp. 497-503.

Cooper, Signe S., "Committees That Work," Journal of Nursing Administration," January-February 1973, p. 3(1).

Cowsert, W. Eugene, "Open Meetings Without Fear," Trustee, September 1979, pp. 47, 49.

Davis, Joseph B., and Bader, Barry S., "The Systems Approach to Patient Safety," Quality Review Bulletin, February 1979, pp. 17-21.

Decker, C. Richard and Johnson, Ross H., "How to Make Committees More Effective," Management Review, February 1976, pp. 34-70.

Dennis, Michael, "A Problem-Solving Package for Building Committees," Dimensions in Health Service, p. 54.

Dietz, James W., and Phillips, James L., "The Quality Assurance Committee in the Hospital Structure," Quality Review Bulletin, January 1980.

Dunsing, Richard J., "Cure for the Dull Meeting: Careful Planning," Health Services Manager, Vol. 11, No. 9, September 1978, pp. 64.

Dunsing, Richard J., "We've Got to Stop Meeting Like This," Trustee September 1979, pp. 41-42, 44-45.

Eresian, John G., "The Audit Committee: Watchdog for the Board," Trustee, March 1979, pp. 43-45, 47, 49.

Etal, Roy A., "Prospective vs Retrospective Data for Evaluating Emergency Care: A Research Methodology," Journal of the American College of Emergency Physicians, April 1979, p. 142-6.

Ferderber, Charles J., "Practical Pointers: Time - The Executive's Dilemma," Hospital Financial Management, February 1980, pp. 52-54, 56.

Friedman, Emily, "Breaking the Bottleneck: The Administrator As Delegator," Hospitals, Vol. 52, 1 February 1978, pp. 71-72, 74-76, 78.

Georgopoulos, Basil S., and Mann, Floyd C., "The Hospital as an Organization," Hospital and Health Services Administration, Vol. 7, No. 4, Fall 1962, pp. 50-64.

Gregg, Thomas E. and Hahn, Jack A. L., "Demystifying Quality Assurance," Trustee, February 1980, pp. 16-18.

Grozuczak, JoAnn and Olander, George A., "A Problem-Oriented Approach to Medical Staff Committee Structure," The Hospital Medical Staff, November 1974, pp. 10-15.

Heywood, James D., "Manage Your Time by Managing Your Activities," Supervisory Management, May 1974, pp. 3, 5-7.

Hischke, Linda S., "Evaluating the Quality of Health Care - A Coordinated Effort," Texas Hospitals, December 1977, pp. 13-14.

Housley, Charles, "Materiel Management: Working with the Hospital Committee Structure," Dimensions in Health Service, December 1976, pp. 10-11.

Housley, Charles E., "Making the Standardization Committee More Effective," Hospital Progress, August 1976, pp. 58, 62, 68.

Huseman, Richard C.; Alexander, Elmore R., III; Henry, Charles L., Jr.; and Denson, Fred A., "Managing Change Through Communication," Personnel Journal, January 1978, pp. 20-25.

"I Really Hope You Can Be There," Research Institute, Personal Report for the Executive, 26 February 1980, pp. 4.

"Issues in Quality Assurance: QRB Editorial Advisory Board," Quality Review Bulletin, February 1979, pp. 11-16.

Janke, Thomas A., "How to Manage (Practically) Anything - Systematically," U.S. Army-Baylor University Bulletin of Continuing Education, Fall and Winter 1979, pp. 1-9.

"January 1981 is Implementation Date for Quality Assurance Standard," Small and Rural Hospital Report, September/October 1980, pp. 3.

Jay, Antony, "How to Run a Meeting," Harvard Business Review, March-April 1976, pp. 43-57.

Johnson, Charles R., "The Impossibility of Group Decisions," Dimensions in Health Service, May 1979, pp. 2-7.

Kast, Fremont E. and Rosenzweig, James E., "Administration and Systems Concepts," Hospital and Health Services Administration, Vol. XI, No. 4, Fall 1966, pp. 17-33.

Laxdal, O. E.; Jennett, P. A; and Wilson, T. W., "Improving Physician Performance by Continuing Medical Education," Canadian Medical Association Journal, Vol. 118, 6 May 1978, pp. 1051-58.

"Learning the Ropes as a Committee Chairman," Trustee, September 1979, pp. 32-37.

Lindberg, Curt, "Realign Committees that Perform Medical Staff - Hospital Functions," Hospitals, Vol. 50, 1 August 1976, pp. 89-90.

"Making Committees Work," The SESCO Report for Health Care Facilities, April 1980, p. 2.

Mancano, John M., "Handbooks Simplify, Improve Committee Work," Hospitals, Vol. 46, 16 December 1972, pp. 49-50.

Mattern, Clara L., "The Legal Perspective: Make Your Credentialing Procedures Work For You," Trustee, August 1979, pp. 8-9, 13-15.

McGraw, Van, "It's Not the Committee, It's How You Use It," Hospital Financial Management, February 1976, pp. 23-26.

Mears, Peter, "Structuring Communication in a Working Group," Journal of Communication, Winter 1974, pp. 71-79.

Moore, K. R., "What Nurses Learn from Nursing Audit," Nursing Outlook, Vol. 27, April 1979, pp 254-8.

Moore, Terence F. and Lorimer, Bernard E., "The Matrix Organization in Business and Health Care Institutions: A Comparison," Hospital and Health Services Administration, Fall 1976, pp. 26-34.

Nelson, Alan R., "Peer Review and CME: Closing the Loop," The Hospital Medical Staff, Vol. 6, March 1977, p. 19.

"New Quality Assurance Standard Approved," Perspectives on Accreditation, May/June 1979, pp. 1-3.

Neuhauser, Duncan, "The Hospital as a Matrix Organization," Hospital and Health Services Administration, Vol. 17, No. 4, Fall 1972, pp. 8-25.

Osterhaus, Leo B., "Systems Concepts for Hospitals," Hospital and Health Services Administration, Vol. XIV, No. 3, Fall 1969, pp. 57-66.

Ostrow, Patricia C. and Jones, Elizabeth, "Peer Review for Non-Physicians," Hospitals, 1 December 1979, pp. 66-69.

"Quality Assurance Implementation Date Set," Perspectives on Accreditation, January/February 1980, p. 1.

Rank, B. K., "Committees - Effective and Otherwise," The Medical Journal of Australia, 13 January 1973, pp. 77-78.

Sabatino, Frank G., "Different Perspectives on Quality Assurance," Quality Review Bulletin, 10 April 1980, pp. 2.

Salman, Steven L., "A Systems Approach Can Ensure High-Quality Care and Low Costs," Hospitals, 16 March 1979, pp. 79-82.

Sanazaro, Paul J., "Medical Audit, Continuing Medical Education and Quality Assurance," The Western Journal of Medicine, Vol. 125, September 1976, pp. 241-51.

Scott, Robert E., "Principles and Techniques of Time Management," Hospital Progress, May 1978, pp. 56-58, 90.

Smith, Noel G., "A System-wide Quality Assurance/Risk Management Program, "The Hospital Medical Staff, August 1979, pp. 40-44.

Spencer, Frank C., "Observations on the Functioning of Committees," Surgery, Vol. 78, No. 3, September 1975, pp. 394-400.

Stein, Leonard S., "A Guide for Effective CME Committee Action," The Hospital Medical Staff, September 1978, pp. 16-18.

Tasklanganos, Angelos A., "The Committee in Business: Asset or Liability," Personnel Journal, February 1975, pp. 90-92.

"The Board's Role in Risk Management," Trustees, September 1979, pp. 55-62.

"The Importance of Strong Leadership," Hospital Formulary, Vol. 12, February 1977, pp. 117, 119.

Thompson, Richard E., "Beyond Medical Audit: Relating Medical Care Evaluation to Patient Care," Resident & Staff Physician, May 1978, pp. 91-93.

"Walter Reed Quality Assurance Activities Described," Hospital Peer Review, May 1978, pp. 70-73.

Whitfield, A. G. W., "How to Chair a Committee," British Medical Journal, 30 September 1978, pp. 936-937.

Willis, Anthony J. P., "Doctors on Committees," The Lancet, 10 July 1976, pp. 105.

Woodward, Carl E., "How to Make Joint Conference Committee Meetings More Productive," Trustees, January 1975, pp. 42-43.

Vanagunas, Audrone, "Quality Assessment: Alternate Approaches," Quality Review Bulletin, February 1979, pp. 7-10.

Vanagunas, Audrone; Egelston, E. Martin; Hopkins, Julie; and Walczak, Regina M., "Principles of Quality Assurance," Quality Review Bulletin, February 1979, pp. 3-6.

Waters, J. H., "Audit System Upgrades Performance, Downplays Discipline," Hospital Medical Staff, June 1979, p. 2-6.

Webber, James B. and Dula, Martha A., "Effective Planning Committees for Hospitals," Harvard Business Review, Vol. 52, May-June 1974, pp. 133-142.

Welch, Larry, "The Emergence of an Interdisciplinary Approach to Patient Care Review," Hospitals, Vol. 52, 16 May 1978, pp. 64.

"Worth Repeating: Questions on Quality Assurance," Perspectives on Accreditation, September/October 1979, pp. 10-11.

"Worth Repeating: Questions on Quality Assurance," Perspectives on Accreditation, November/December 1979, pp. 5.

Government Documents

Army Regulation 40-2, "Army Medical Treatment Facility: General Administration," 30 March 1978.

Army Regulation 40-5, "Health and Environment," 25 September 1974.

Army Regulation 40-400, "Patient Administration," with Changes 1 and 2, and with HSC Supplement 1, 1 August 1978.

Health Services Command Ambulatory Patient Care Model #1, "A Central Appointment System," July 1974.

Health Services Command Ambulatory Patient Care Model #18, "Clinical Support Division," 1 October 1977.

Health Services Command Letter, HSOP-PR, "UR Program," 9 November 1977.

Health Services Command Pamphlet 20-1, "Accreditation Guide for Army Hospitals," with Change 1, 21 March 1980.

Health Services Command Pamphlet 40-1, "Committees, Boards and Functions," January 1979.

USAMEDDAC Regulation 15-1, "Boards, Councils and Committees," with Change 1, 5 February 1980.

US Comptroller General, Report to the Congress of the United States; Military Medicine is in Trouble: Complete Reassessment Needed, HRD 79-107, 16 August 1979.

Unpublished Materials

Threet, Allan R., "Continuing Medical Education as a Function of Quality Assurance," a Literature Research Paper for Quality Assessment in Health Care Administration, U.S. Army-Baylor University Graduate Program in Health Care Administration, Academy of Health Sciences, Fort Sam Houston, Texas, 18 June 1979.

Threet, Allan R., "A Study to Determine the Optimum Feasible Plan for a Comprehensive Quality Assurance Program Integrated with a Continuing Medical Education Program at Santa Rosa Medical Center, San Antonio, Texas," a Health Care Systems Research Paper for the Graduate Health Care Administration Program, U.S. Army-Baylor University, Academy of Health Sciences, Fort Sam Houston, Texas, 29 June 1979.

Interviews

Bizer, James E., Colonel, MSC, Executive Officer, Ireland Army Hospital and Fort Knox Medical Department Activity, Fort Knox, KY, 8 January 1980.

Baldwin, Kenneth B., Lieutenant Colonel, MSC, Chief, Patient Administration Division, Ireland Army Hospital and Fort Knox Medical Department Activity, Fort Knox, KY, 20 May 1980.

Blount, Richard B., Colonel, MC, Chief, Professional Services Division, Ireland Army Hospital and Fort Knox Medical Department Activity, Fort Knox, KY, 18 September, 19 October and 7 November 1979.

Forshey, David, Major, MSC, Chief, Clinical Support Division, Ireland Army Hospital and Fort Knox Medical Department Activity, Fort Knox, KY, 12 January 1980.

Galey, James H., Major, MSC, Comptroller, Ireland Army Hospital and Fort Knox Medical Department Activity, Fort Knox, KY, 14 January 1980.

Rose, Robert D., Lieutenant Colonel, MSC, Former Chief, Clinical Support Division, Ireland Army Hospital and Fort Knox Medical Department Activity, Fort Knox, KY, 28 January 1980.

Soltys, Anthony W., Colonel, ANC, Chief, Department of Nursing, Ireland Army Hospital and Fort Knox Medical Department Activity, Fort Knox, KY, 14 November 1979.

Taylor, John F., Colonel, MC, Commander, Ireland Army Hospital and Fort Knox Medical Department Activity, Fort Knox, KY, 2 October, 7 November, 21 December 1979 and 8 January 1980.

Wimett, Joan, Major, ANC, Infection Control Nurse, Ireland Army Hospital and Fort Knox Medical Department Activity, Fort Knox, KY, 26 May 1980.

Youngs, Brian L., Lieutenant Colonel (P), MC, Chief, Preventive Medicine Activity, Fort Knox Medical Department Activity, Fort Knox, KY, 3 and 8 April 1980.

Other Sources

Bevis, Em, M.S., R.N., Dean, School of Nursing, University of Southern Georgia, Lecture to the Fort Knox, KY, Ireland Army Hospital Department of Nursing Workshop, "The Dynamics of Motivating Change," 29 March 1980.

Dean, Olga, R.N., Field Representative, Hospital Accreditation Program, Joint Commission for Accreditation of Hospitals, Lectures to the Fort Knox, KY, Ireland Army Hospital staff, "The New JCAH Quality Assurance Standard," 16 and 24 April 1980.

Gill, Sandra, Management Consultant and Organizational Development Specialist, Kaiser-Parmanente, Lecture to American College of Hospital Administrators 23D Congress on Administration, "Managing Meetings for Results," 20 February 1980.

Hardman, James R., Assistant Professor, Baylor University, Lecture to U.S. Army-Baylor University Health Care Administration Graduate Program, "Committees and How to Make Them Effective," 2 March 1979.

Joint Commission on Accreditation of Hospitals 1980 Accreditation Manual for Hospitals.

Joint Commission on Accreditation of Hospitals Seminar on Quality Assurance, Nashville, TN, 28-29 February 1980.

Kemelgor, Bruce, Assistant Professor, University of Louisville, Lecture to Fort Knox, KY, Ireland Army Hospital Staff, "Decision Making in Health Care Organizations," 20 November 1979.

McLain, Fredrick R., Assistant Professor, Baylor University, Lecture to U.S. Army-Baylor University Health Care Administration Graduate Program, "Toward a Definition of Quality," 5 April 1979.

Thompson, Richard E., M.D., Quality Assurance Consultant, Lecture to Kentucky Peer Review Organization participants, "Audit/MCE Update; A New Perspective in Quality Assurance," 6 September 1979.

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